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INDEX ARRANGEMENT

Sequence of Subheads in Index

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Key to Abbreviations in This Index

- Or.—Original Article.
C. R.—Case Report.
E. C.—Editorial Comment.
C. N.—Clinical Notes.

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Contra Costa County Medical Society President, Kabo Daily, 314 Tentb Street, Richmond. Secretary, Clifford E. Dieterich, 1306 Pomona Avenue, Crockett. Meeting, <i>Second Tuesday, 8:00 p. m.</i>	Napa County Medical Society President, Frank X. McGreane, Silverado Sanatorium, Calistoga. Secretary, M. M. Booth, Bruck Building, St. Helena. Meeting, <i>First Wednesday.</i>	Santa Clara County Medical Society President, Merlin T.-R. Maynard, 241 East Santa Clara Street, San Jose. Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose. Meeting, <i>Third Wednesday, 8:00 p. m., Medico-Dental Building, San Jose.</i>
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Humboldt County Medical Society President, John N. Chain, Fourth and E Streets, Eureka. Secretary, Joseph S. Woolford, 350 E Street, Eureka. Meeting, <i>First Thursday.</i>	Placer County Medical Society President, William M. Miller, Auburn. Secretary, Robert A. Peers, Colfax. Meeting, <i>At Call of President.</i>	Shasta County Medical Society President, Clarence C. Gerrard, Redding. Secretary, Bertram L. Trelstad, 1536 Market Street, Redding. Meeting, <i>Second Monday.</i>
Imperial County Medical Society President, William A. Clarke, Holtville. Secretary, Claude F. Peters, 722 Main Street, Brawley. Meeting, <i>Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.</i>	Riverside County Medical Society President, Thomas A. Card, 3616 Main Street, Riverside. Secretary, W. Philip Corr, 3616 Main Street, Riverside. Meeting, <i>Second Monday, 8:00 p. m., Library, Riverside Community Hospital.</i>	Siskiyou County Medical Society President, Charles Pius, Yreka. Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka. Meeting, <i>Sunday on call.</i>
Inyo-Mono County Medical Society President, Lloyd S. Bambauer, 705 Home Street, Bishop. Secretary, Clarence L. Scott, 609 Elm Street, Bishop. Meeting, <i>Fourth Wednesday, Methodist Church, Bishop, except December, January, February.</i>	Sacramento Society for Medical Improvement President, Norris R. Jones, M. D., 1127 Eleventh Street, Sacramento. Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento. Meeting, <i>Third Tuesday, 8:30 p. m., Auditorium, Sacramento.</i>	Solano County Medical Society President, H. Randall Madeley, 727 Sonoma Street, Vallejo. Secretary, John W. Green, Box 539, Vallejo. Meeting, <i>Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.</i>
Kern County Medical Society President, C. S. Compton, 428 C Street, Bakersfield. Secretary, Eric F. Colby, Hopkins Building, Bakersfield. Meeting, <i>Third Thursday, 8:00 p. m.</i>	San Benito County Medical Society President, J. M. O'Donnell, Hollister. Secretary, L. E. Smith, Hollister. Meeting, <i>At Call of President.</i>	Sonoma County Medical Society President, S. Z. Peoples, 159 Kentucky Street, Petaluma. Secretary, T. E. Albers, 600 B Street, Santa Rosa. Meeting, <i>Second Thursday.</i>
Kings County Medical Society President, P. K. Edmunds, Corcoran. Secretary, William A. Johnstone, Hanford. Meeting, <i>Second Monday, 8:00 p. m., Legion Hall, Hanford.</i>	San Bernardino County Medical Society President, Walter S. Cherry, Rialto. Secretary, A. E. Varden, Medico-Dental Building, San Bernardino. Meeting, <i>First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.</i>	Stanislaus County Medical Society President, Richard D. Husband, P. O. Box 709, Modesto. Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto. Meeting, <i>Second Friday, 7:30 p. m., Hotel Hughson.</i>
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Los Angeles County Medical Association 1925 Wilshire Boulevard, Los Angeles President, Roy E. Thomas, 1136 W. Sixth Street, Los Angeles. Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles. Meetings, <i>First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.</i>	San Francisco County Medical Society 2180 Washington Street, San Francisco President, William Reilly, 490 Post Street, San Francisco. Secretary, L. Henry Garland, 2180 Washington Street, San Francisco. Meetings, <i>Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.</i>	Tulare County Medical Society President, Ray E. Cronemiller, 160 South E Street, Exeter. Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia. Meeting, <i>Sunday Evening once a month.</i>
Marin County Medical Society President, Harry N. Hensler, Home Market Building, San Anselmo. Secretary, Carl W. Clark, 510 B Street, San Rafael. Meeting, <i>Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.</i>	San Joaquin County Medical Society President, Hugh J. Bolinger, Farmers and Merchants Bank Building, Lodi. Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton. Meetings, <i>First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.</i>	Ventura County Medical Society President, Harry E. Barker, 1484 East Main Street, Ventura. Secretary, A. A. Morrison, 625 Main Street, Santa Paula. Meeting, <i>Second Tuesday, Ventura County Country Club.</i>
Mendocino-Lake County Medical Society President, Dallas L. Wagner, 615 Main Street, Fort Bragg. Secretary, Royal Scudder, Fort Bragg. Meeting, <i>On Call.</i>	San Luis Obispo County Medical Society President, F. W. Yocom, 732 Thirteenth Street, Pao Robles. Secretary, E. M. Bingham, County Health Department, San Luis Obispo. Meeting, <i>Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.</i>	Yuba-Sutter-Colusa County Medical Society President, Ben F. Miller, Yuba City. Secretary, Leon M. Swift, 1. O. O. F. Building, Marysville. Meeting, <i>First Tuesday.</i>

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Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

ENDOCRINOLOGY: A CRITICAL ANALYSIS

(Continued from Text Page 51)

of Internal Medicine. New York: D. Appleton-Century Company, Inc., pp. 451-509, 1938.

19. Kessel, F. K.: Morbus Cushing; Ein Überblick über Klinik und Kasuistik des basophilen Hypophysenadenoms, *Ergebn. d. inn. Med. u. Kinderh.*, 50:620-678, 1936.

20. Long, C. N. H.: Diabetes mellitus in light of our present knowledge of metabolism (Nathan Lewis Hatfield lecture), *Tr. & Stud., Coll. Physicians, Philadelphia*, 7:21-46 (April), 1939.

21. McQuarrie, Irvine, Johnson, R. M., and Ziegler, M. R.: Plasma electrolyte disturbance in patient with hypercorticotadrenal syndrome contrasted with that found in Addison's disease, *Endocrinology*, 21:762-772 (Nov.), 1937.

22. Osgood, E. E.: Pituitary cachexia? *Endocrinology*, 23:656-660 (Nov.), 1938.

(Continued on Page 7)

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ENDOCRINOLOGY: A CRITICAL ANALYSIS

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The "Magic Mountain" personality of the tuberculous, described by Thomas Mann, is symbolic of their uncertainty, mental unrest and feeling of social insecurity. It is due to the failure of the public to understand the tuberculous. Fear that the patient experiences about the attitude of others makes him depressed and nervous, gloomy and unfriendly and ashamed of his illness. The cured tuberculosis patient should have a fair chance to return to normal life.—Morton A. Seidenfeld, *Science News Letter*, December 9, 1939.

Regulations against expectoration in public places are not merely an exhortation to good manners; they are an expression of a theory as to the mode of infection in pulmonary tuberculosis which was held before the discovery of the bacillus and was the common property of all physicians.—S. Roodhouse Gloyne, M. D., *Tubercle*, February, 1940.

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The American Academy of Pediatrics is sponsoring an educational campaign to create a demand for protective examinations on the part of employers and employees. According to the Academy, approximately 2 per cent of the teachers actively engaged in elementary and secondary schools in the United States suffer from tuberculosis.—*The Survey*, January, 1940.

There is no single absolutely reliable sign or symptom of activity in tuberculosis. Its determination must rest upon the most careful and thorough consideration of all of the general and local symptoms and signs, together with the results of the various laboratory and clinical studies.—Alex James Miller, *New York State Journal of Medicine*, December, 1939.

The sputum-positive cases are a matter of grave concern. They insist upon being discharged to their families and the community; yet segregation is of first importance in controlling tuberculosis. By segregation did our ancestors rid the country of leprosy.—Welsh Natl. Mem. Assn. Report, Tubercle, November, 1939.

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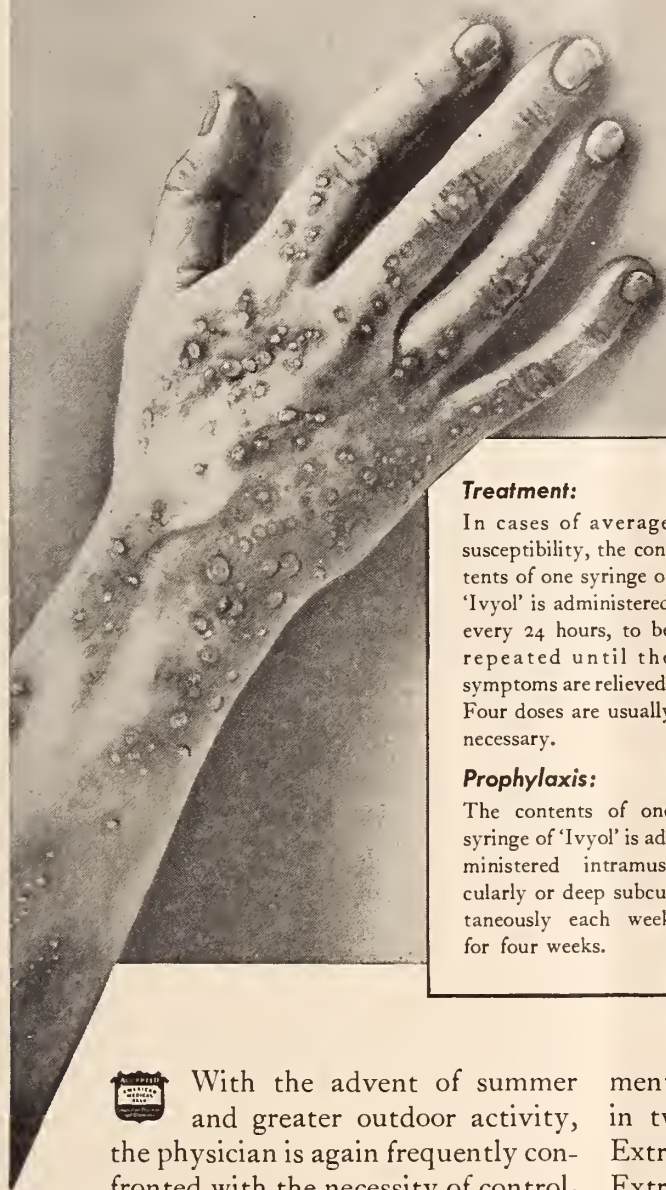
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BOOK REVIEWS

BOOKS RECEIVED

An Anatomical Analysis of Sports. By Gertrude Hawley, M. A., formerly in charge of Physical Education for Women at Northwestern and Stanford Universities. Cloth. Pp. 191. Price, \$3.00. New York: A. S. Barnes & Company, 1940.

Injection Treatment of Varicose Veins and Hemorrhoids. By H. O. McPheeters, M. D., F. A. C. S., formerly Director of the Varicose Vein and Ulcer Clinic, Minneapolis General Hospital; Attending Physician, New Asbury, Fairview and Northwestern Hospitals, Minneapolis, Minn., and James Kerr Anderson, M. D., F. A. C. S., Instructor in Surgery, University of Minnesota School of Medicine, Fellow, American Proctologic Society; Adjunct Surgeon, Minneapolis General Hospitals; Attending Surgeon, St. Mary's, Abbott and Northwestern Hospitals, Minneapolis, Minn. Second Revised Edition. Cloth. Pp. 323, illustrated with 86 half-tones and line engravings and one color plate. Price, \$4.50. Philadelphia: F. A. Davis Company, 1939.

Health Under the "El." The story of the Bellevue-Yorkville Health Demonstration in Mid-Town New York. By C.-E. A. Winslow, Professor of Public Health, Yale University School of Medicine, and Savel Zimand, formerly Administrative Director, Bellevue-Yorkville Health Demonstration. A Foreword by Fiorello H. La Guardia, Mayor of New York City. Published for the Milbank Memorial Fund. Cloth. Pp. 203. Price, \$2.25. New York: Harper & Brothers, Publishers, 1937.

The Poison Trail. By William F. Boos, M. D. Cloth. Pp. 380. Price, \$3.00. New York: Hale, Cushman & Flint, 1939.

Obesity and Leanness. By Hugo R. Rony, M. D., formerly Associate in Medicine and Chief of Endocrine Clinic, Northwestern University School of Medicine, Chicago; formerly Attending Physician, Cook County Hospital, Chicago; Member Central Society for Clinical Research, The Association for the Study of Internal Secretions, etc. Cloth. Pp. 300, illustrated with 32 engravings. Price, \$3.75, net. Philadelphia: Lea & Febiger, 1940.

The New International Clinics. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M. D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Volume II, New Series Three. Cloth. Pp. 365, illustrated. Philadelphia: J. B. Lippincott Company, 1940.

Psychological and Neurological Definitions and the Unconscious. By Samuel Kahn, M. D., Ph. D., author of *Sing Sing Criminals; Mentality and Homosexuality, and How to Study*; associated with the Mount Sinai Hospital Mental Health Clinic and the New York State Psychiatric Institute; formerly on the faculties of New York University, Georgetown and George Washington Universities, etc. Cloth. Pp. 219. Price, \$2.00. Boston: Meador Publishing Company, 1940.

Operative Surgery. By J. Shelton Horsley, M. D., LL. D., F. A. C. S., Attending Surgeon, St. Elizabeth's Hospital, Richmond, Va., and Isaac A. Bigger, M. D., Professor of Surgery, Medical College of Virginia, Surgeon-in-Chief, Medical College of Virginia Hospitals, Richmond, Va. With Contributions by C. C. Coleman, M. D., F. A. C. S., Professor of Neurological Surgery, Medical College of Virginia; John S. Horsley, Jr., M. D., Associate Professor of Surgery, Medical College of Virginia; Austin I. Dodson, M. D., F. A. C. S., Professor of Urology, Medical College of Virginia; and Donald M. Faulkner, M. D., Associate Professor of Orthopedic Surgery, Medical College of Virginia. Two volumes. Fifth Edition. Cloth. Pp. 1,567, illustrated by Helen Lorraine. Price, \$18 per set. St. Louis: The C. V. Mosby Company, 1940.

Cancer. A Manual for Practitioners. By a committee representing the Massachusetts Medical Society and the American Society for the Control of Cancer. Cloth. Pp. 284. Boston: Rumford Press, 1940.

Physicians' Handbook on Birth and Death Registration. Containing International List of Causes of Death. Ninth Edition. Prepared under the Supervision of Dr. Halbert L. Dunn, Chief Statistician for Vital Statistics, U. S. Department of Commerce, Bureau of the Census. Paper. Pp. 94. Price, 15 cents. Washington: United States Government Printing Office, 1939.

Doctors in Shirt Sleeves. Musings on Hobbies, Meals, Patients, Sport and Philosophy. Edited by Sir Henry Bashford. Cloth. Pp. 294. Price, \$2.50. New York: Veritas Press, 1940.

Medicine and the State. The Relation Between the Private and Official Practice of Medicine, with Special Reference to Public Health. By Sir Arthur Newsholme, K. C. B., M. D., F. R. C. P. With Foreword by William H. Welch, M. D., LL. D. Cloth. Pp. 300. Baltimore: Williams & Wilkins Co., 1932.

BOOK REVIEWS

Surgical Pathology of the Diseases of the Mouth and Jaws. By Arthur E. Hertzler, M. D., Surgeon to the Agnes Hertzler Memorial Hospital, Halstead, Kansas, Professor of Surgery, University of Kansas. Cloth. Pp. 248, with 206 illustrations. Price, \$5. Philadelphia: J. B. Lippincott Company, 1938.

This last book of Hertzler's follows very much the same plan as many of the others in which he lists the pathogenesis, pathology and histology of many things which he has personally seen. It is an interesting catalogue covering most of the common lesions of the mouth and jaws which the average physician will encounter. As such, it is certainly worth reading.

On the other hand, it lacks what the reviewer feels to be an essential of any pathological treatise at this time, namely, an intimate association with clinical behavior and a similar association with x-ray therapy. Certainly, no work on pathology should close any subject in any of its parts without at least discussing the x-ray sensitivity of various and particular lesions.

Finally, one wonders concerning the difference between pathology and surgical pathology. If the subject of surgical pathology is so small that it needs to be segregated from the general field of study of disease, it is not worth ten volumes. If the subject of pathology is so large that specialized specialties should be developed within the subject, there are better classifications than this.—J. L. C.

Cancer Handbook of the Tumor Clinic, Stanford University School of Medicine. Edited by Eric Liljencrantz, M. D., Chief of Tumor Clinic, Stanford University School of Medicine; Consultant in Neoplastic Disease, United States Naval Hospital, Mare Island, and United States Marine Hospital, San Francisco. Cloth. Pp. 114. Price, \$3.00. Stanford University: Stanford University Press, 1939.

This is a small volume of 100 pages, outlining in brief the treatment of cancer in the Tumor Clinic of Stanford University School of Medicine. Following a chapter on the cancer problem in general, and another on principles of radiation therapy, it then takes up the diagnosis and treatment of tumors in various locations in the body. Being originally assembled as a syllabus for postgraduate instruction it is especially brief and dogmatic in its statement of procedures to be followed, with some of which other clinics might be in disagreement. It is illustrated by photographs and diagrams.

This reviewer considers it a good practical volume for the purpose for which it was intended—an outline of procedures that can be followed, telling as well what can be expected from such procedures and, of course, is not a text on cancer. A bibliography is appended. O. H. P.

Trapping the Common Cold. By George Sanford Foster, M. D. Cloth. Pp. 125. Price, \$1.25. New York: Fleming H. Revell Company, 1940.

A highly dogmatic and opinionated work. Statements, as of fact, are in no way confirmed; they are not even supported by generally-expressed views among the profession. An example of pseudoscience by a pseudoscientist.

(Continued on Next Page)



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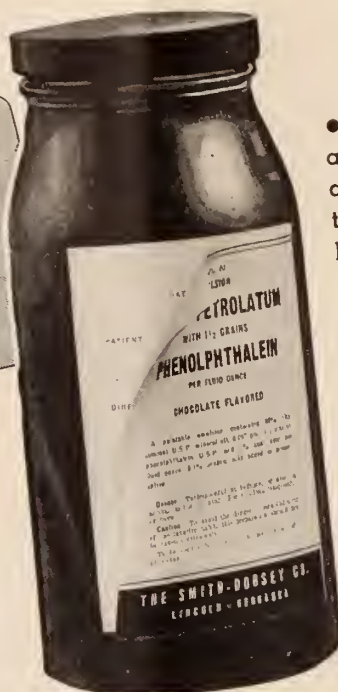


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BOOK REVIEWS

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The author's development of his subject is mindful of the effort of one obsessed. He states that prevention of the common cold is as elementary and simple as anything in everyday life. Yet, as he unfolds it, it is seen to be a prescription for an arduous ritual for daily living. Every hour of the day and night is molded into his scheme of rigid discipline. He calls it a "systematic régime," a "painstaking life." A more fitting term would be futile drudgery. One is invited to trade the risk of an occasional cold for the status of slavery to its prevention.

Among the author's numerous obsessions is the omnipresence and omnipotence of atmospheric dust. Dust particles are said to be the great universal vehicles for transportation of cold germs. Even on a raft in mid-ocean he says the air would be "polluted" by particles of wood dust! Thus do cold germs forever "lurk" in our environment. Another choice brainstorm is his dissertation on the "soiled stomach." The stomach, says he, is so foul from fermentation of the evening meal that it must be washed before breakfast every morning! This makes the stomach "clean and sweet." The swallowed water, after polishing the stomach, is absorbed by the lymphatics, and "goes over the entire body, bathing and rinsing clean every corner of it!"

S. N. P.

Shock: Blood Studies as a Guide to Therapy. By John Scudder, M. D., Med. Sc. D., F. A. C. S., from the Surgical Pathology Laboratory of the College of Physicians and Surgeons, Columbia University, and the Department of Surgery, the Presbyterian Hospital, New York City. Cloth. Pp. 315, with 55 illustrations, and five plates, three of which are in color. Price, \$5.50. Philadelphia: J. B. Lippincott Company, 1940.

The author presents a comprehensive survey of the historical and experimental evidence on shock with special emphasis on the importance of the hematocrit, specific gravity of the blood, plasma proteins, and blood potassium determination in the early recognition of shock and the guidance of its treatment. He gives in detail a number of representative cases following trauma, hemorrhage, operation, burns and perforated ulcer, with the details of and

reasons for the treatment. In the treatment he describes the indications for transfusions, hypertonic saline injections, and the cortical extract.

Too often in the handling of shock hit or miss methods are used. This book should help us all to make our punches more scientific and telling in the fighting of this dreaded specter.

It is an outstanding monograph on shock which will be a welcome addition to the hospital library. A. J. H.

Proceedings of the Tenth International Congress of Military Medicine and Pharmacy, Washington, D. C., May 7 to 19, 1939. Volume II. Paper. Pp. 303. Price, 50 cents. Washington, D. C.: United States Government Printing Office, 1939.

This volume reports the discussion of present-day principles and practices on seven assigned topics by eminent military medical authorities. Also included in the volume is a symposium on the selection of flying personnel and the maintenance of their efficiency.

The discussions, and conclusions drawn therefrom, provide interesting reading even to nonmilitary physicians as is readily seen from the topic titles: Organization and functions of the medical service in colonial expeditions; Probable casualties in war; Practical anesthesia and analgesia in war surgery; Practical use of oxygen therapy with troops; Emergency treatment and apparatus for fractures of jaws in war; Effects of intermaxillary distance on hearing, ear noises and headaches.

F. C. S.

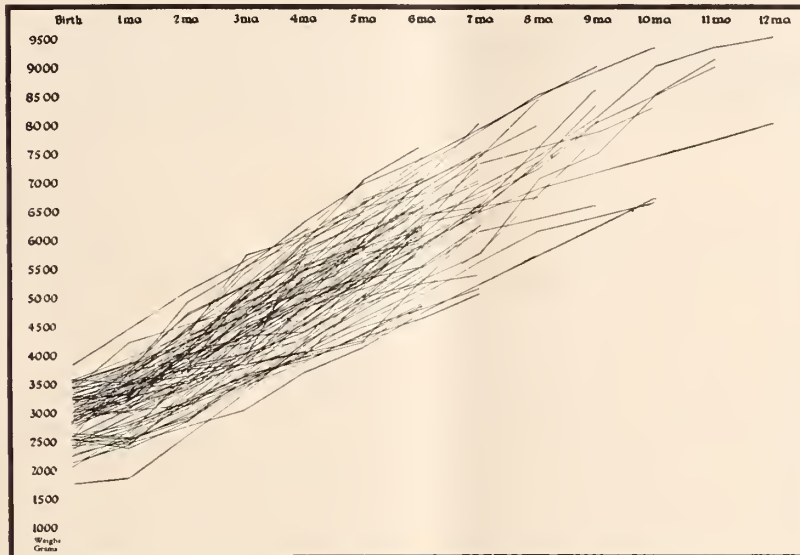
Manual of Graduate Training in Surgery: American College of Surgeons.

Pursuant to its aim of raising the standards of surgery, the American College of Surgeons has published a 24-page "Manual of Graduate Training in Surgery" in which are incorporated the requirements for its approval of programs of training in general surgery and the surgical specialties in hospitals of the United States and Canada.

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(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 16)

and several committees of the College. The new "Manual" is an elaboration of the "Fundamental Principles and Criteria" and will in the future be applied in determining eligibility for the Approved List to be published in the Approval Number of the College Bulletin in October of each year.

The College recognizes three principal types of institutions as offering acceptable programs of graduate training in surgery: (1) universities or teaching hospitals supervised by departments of surgery of medical schools and graduate schools; (2) fellowships in recognized clinics and other organized groups; and (3) selected hospitals which by utilizing their own facilities to the fullest are able to carry acceptable programs through to completion, or which have supplemented their educational program, particularly in the basic medical sciences, through affiliation with medi-

cal schools and graduate schools.

The Minimum Standard for Graduate Training in Surgery which is included in the new "Manual" comprises five clauses, concerned with (1) duration and objective of the program; (2) organization and supervision; (3) basic medical sciences; (4) clinical material; and (5) organized study.

Under the requirements, an acceptable program requires a minimum of two and preferably three or more years of training in surgery, beyond at least one year of general internship. Such preparation is now necessary in order for an applicant for fellowship in the American College of Surgeons to meet the qualifications in respect to training, as set forth in the following resolution passed by the Board of Regents on May 10, 1936. The address of the American College of Surgeons is 40 East Erie Street, Chicago. Bowman C. Crowell and Malcolm T. MacEachern, Directors.

Surgical Technique and Principles of Operative Surgery. By A. V. Partipilo, M.D., F.A.C.S., Associate Professor and Director of the Division of Operative Surgery and Surgical Anatomy, Loyola University School of Medicine; Senior Attending Surgeon, St. Mary's Hospital; Attending Surgeon, Mercy Hospital. Foreword by Alton Ochsner, M.D., William Henderson, Professor and Director of the Department of Surgery, The Tulane University School of Medicine, New Orleans, Louisiana. Original illustrations by W. C. Shepard. Third Edition. Cloth. Pp. 567. Chicago: Chicago Postgraduate School of Surgery, 1938.

The author's aim of presenting a laboratory guide for the student and a practical reference book for the surgeon has been admirably accomplished. The preliminary chapters deal with suture materials, the methods of tying knots, the surgical anatomy of the abdominal wall and peritoneum, and abdominal incisions. Here, as throughout the text, the technical steps are minutely described and profusely illustrated by simple, though highly accurate drawings. Considerable space is devoted to hernias, surgery of the biliary system, and surgery of the gastro-intestinal tract, with brief chapters on the thyroid, the breast, the chest wall, skin grafting, and transfusions. Each operative description is preceded by a discussion of its indications and a review of the appropriate surgical anatomy and physiology. Every chapter is followed by a list of specific but comprehensive questions which cover the presented material. This publication may be readily recommended to the student as a practical guide to operative surgery, and to the surgeon as an excellent reference volume.

A. E. M.

(Continued on Page 20)

the surgeon has been admirably accomplished. The preliminary chapters deal with suture materials, the methods of tying knots, the surgical anatomy of the abdominal wall and peritoneum, and abdominal incisions. Here, as throughout the text, the technical steps are minutely described and profusely illustrated by simple, though highly accurate drawings. Considerable space is devoted to hernias, surgery of the biliary system, and surgery of the gastro-intestinal tract, with brief chapters on the thyroid, the breast, the chest wall, skin grafting, and transfusions. Each operative description is preceded by a discussion of its indications and a review of the appropriate surgical anatomy and physiology. Every chapter is followed by a list of specific but comprehensive questions which cover the presented material. This publication may be readily recommended to the student as a practical guide to operative surgery, and to the surgeon as an excellent reference volume.



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BOOK REVIEWS

(Continued from Page 18)

Injection Treatment of Hernia, Hydrocele, Ganglion, Hemorrhoids, Prostate Gland, Angioma, Varicocele, Varicose Veins, Bursae, and Joints. By Penn Riddle, B. S., M. D., F. A. C. S., Assistant Professor of Clinical and Operative Surgery, Baylor University, College of Medicine; Director of the Varicose Vein Clinic, Parkland Hospital, Dallas, Texas. Cloth. Pp. 290, with 153 illustrations. Price, \$5.50. Philadelphia: W. B. Saunders Company, 1940.

The book is divided into four sections. The first three cover the treatment of hernia, varicose veins and hemorrhoids. The fourth includes the treatment of hydrocele, varicocele, bursae, ganglion, joints, angioma and the prostate gland.

The contents of each of the first three sections include chapters on history with an excellent chapter on the anatomy of the area involved. Then follow chapters on etiology, diagnosis, treatment and complications. The discussions in the fourth section are shorter but seem to cover the material adequately.

The author's attitude toward the treatment of hernia and the injection treatment of the prostate gland and the joints is conservative, in keeping with the uncertainty of the final estimate of these measures of therapy. The section on the treatment of hernia contains a splendid chapter on trusses.

The text is clear and the material is well organized. A large number of illustrations, both photographs and drawings, fully illustrate the material. The book should be valu-

able for class-room use as well as for those practicing physicians who are not thoroughly acquainted with this type of treatment.

S. R. T.

Your Chest Should Be Flat. The Deep Chest Makes Better Soil for Tuberculosis. By S. A. Welsman, M. D., F. A. C. P., Assistant Professor of Medicine, University of Minnesota; Member of Consulting Staff in Tuberculosis, Glen Lake Sanatorium, Oak Terrace, Minnesota; Member of Staff, St. Andrew's and St. Mary's Hospital, Minneapolis, Minnesota. Cloth. Pp. 145, 17 tables and 74 illustrations in 49 figures. Price, \$2.00. Philadelphia: J. B. Lippincott Company, 1938.

The author deals principally with the relationship between the shape of the chest and the tendency to tuberculosis. He outlines the development of the normal and tuberculous chests. By means of the thoracic index, applied to several hundred normal and tuberculous individuals, he shows that the healthy chest is not round and deep, but flat and wide, and that the chest, which harbors the best soil for the growth of the tubercle bacillus, is not flat, but "sunken in" (deep and narrow), i. e., an undeveloped infantile one. An important measure, therefore, in the prevention of tuberculosis, should be the normal development of the chest, and the early correction of chest deformities. The author shows how this can be accomplished by healthy environment, proper diet, exercises for the development of chest musculature, correction of upper respiratory infections, and freedom from the communicable diseases of childhood. As the work of an experienced phy-

(Continued on Page 22)



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I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the —— Gift, the following described real property situate in the County of ——, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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BOOK REVIEWS

(Continued from Page 20)

sician and scientist, it should prove of value, not only for pediatricians, but also for laymen, and especially parents, physical education directors, and social workers. It is, however, surprising to see the words "tuberculous" and "tubercular" used interchangeably. S. D. P.

Scarlet Fever. By George F. Dick, M. D., D. Sc., Professor of Medicine, University of Chicago; Attending Physician, Billings Memorial Hospital; Editor, Department of Infectious Diseases, the Year Book of General Medicine, and Gladys Henry Dick, M. D., D. Sc. Cloth. Pp. 149. Price, \$2.00. Chicago: The Year Book Publishers, Inc., 1938.

This book is a complete summary of our knowledge of the disease as it stands today. It reviews thoroughly the work done to prove a special strain of hemolytic streptococcus as the causative factor. The clinical aspects and complications are detailed. The production of a specific toxin and antitoxin are described.

In the control of the disease they stress the value of cultures, skin tests, active and passive immunization of contacts. They insist on a minimum quarantine period of four weeks, which is longer than that advocated by other workers.

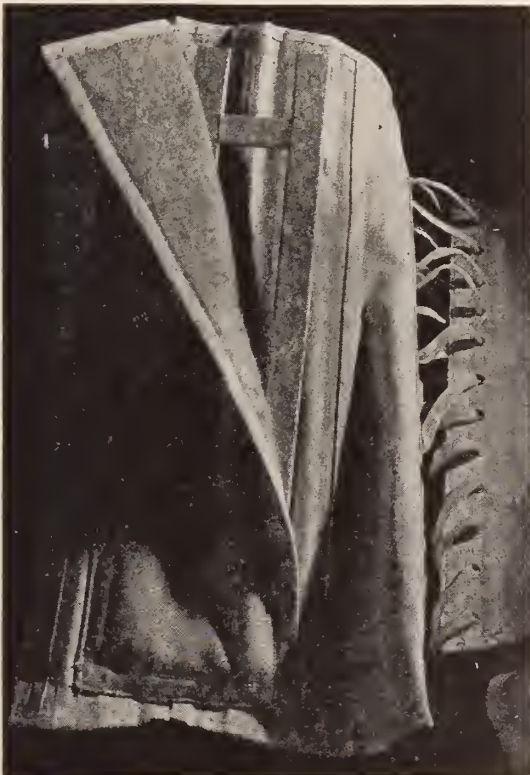
For many years the authors have been staunch advocates for active immunization against the disease, but this has not found universal favor because of the number of injections required and the accompanying reactions. Brief mention is made of recent attempts to produce immunity by oral administration of the toxin. This is still in the experimental stage.

This short volume is favorably recommended to the general practitioner as well as the more serious student of the disease. A complete bibliography is appended. S. H.

One of the needs for the control of tuberculosis today is for greater emphasis on the extent of the disease and less on its declining death rate.—John L. Rice, M. D., New York City Department of Health.

SUPPORT WITH BRACE FOR THE LOW BACK

Commenting on the increased likelihood of patients with spondylolisthesis lesions to suffer from industrial low back injury and on the pathology and symptoms of such injuries, an orthopedic surgeon* in a recent article continues, as follows: "... one begins by putting the patient to bed for anywhere from a few days to two weeks. Physiotherapy is used to give relief from pain and to strengthen the muscles of the back. Sometimes it is well to assure rest to the injured back by immobilization in a plaster jacket. When the patient gets out of bed one must provide him with a low back belt if the symptoms have been mild, or with a spinal brace if rigid support is needed. If, in spite of prolonged conservative treatment, the pain and weakness in the back and the disability continue, one must realize that permanent internal fixation is required."



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*Samuel Kleinberg, M.D.

New York State Journal of Medicine
Volume 39, September 15, 1939



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TWENTY-FIVE YEARS AGO

(Continued from Text Page 52)

he holds himself out to have ordinary skill in his profession. The law does not expect every physician to have unusual ability; merely ordinary skill and ability of the general average of others in a like calling in his vicinity or a similar one. Furthermore, the physician undertakes to make a proper number of visits and to see that his best judgment guides him in making visits and in the time of dismissing his patient. . . .

1 1 1

Termination of Services.—While it is undisputedly true that a physician is not required to nor can he be made to attend a sick or injured person, if he does undertake such services he, as we have shown, enters into an implied contract based on ordinary common sense and justice. He may terminate such a contract, or the patient may terminate it, but in certain recognized ways. In all such common, implied contracts, there are certain well recognized fundamental considerations, as for instance, that either party thereto may terminate the arrangement at his pleasure, but that the party so doing must give the other party to the contract reasonable notice and reasonable time to make other arrangements. . . .

1 1 1

Applicants.—Several of the component county medical societies have adopted the plan of regularly sending in the names of applicants, to the office of the State Society, and awaiting a report from our office before considering any action upon such applications. It is a very wise thing to do, as the JOURNAL has remarked on more than one occasion, and the wisdom of this course was well shown last month

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

when one county society was enabled to keep out a man who had been a notorious abortionist and grafter in another county. . . .

Mayo Clinic and the University of Minnesota.—The Mayo brothers gave a million and a half dollars to the University of Minnesota to be known as the Mayo Foundation and the income to be used for postgraduate teaching, research and the like. Subsequently they, and the Trustees of the University, considered the proposition of forming the Mayo clinic into a sort of regularly recognized and attached postgraduate school of the University. . . .

We certainly congratulate the University of Minnesota; it will soon have one of the best postgraduate departments in existence.

Notice.—Read through the advertising pages of the JOURNAL and place your order with the JOURNAL advertisers. Help those who help the JOURNAL.

From an Original Article on "Treatment of Infection," by Sterling Bunnell, M. D., San Francisco.—The treatment of infection is a very comprehensive subject and one about which we all know considerable, and all I'll try to do in this brief time is to systematize the main principles, arranging our armamentarium against the germs on a rational instead of empirical basis. Then the technique of the ways and means of carrying out these principles will depend on one's current ingenuity. . . .

(Continued on Page 28)

STUDIES IN THE AVITAMINOSES



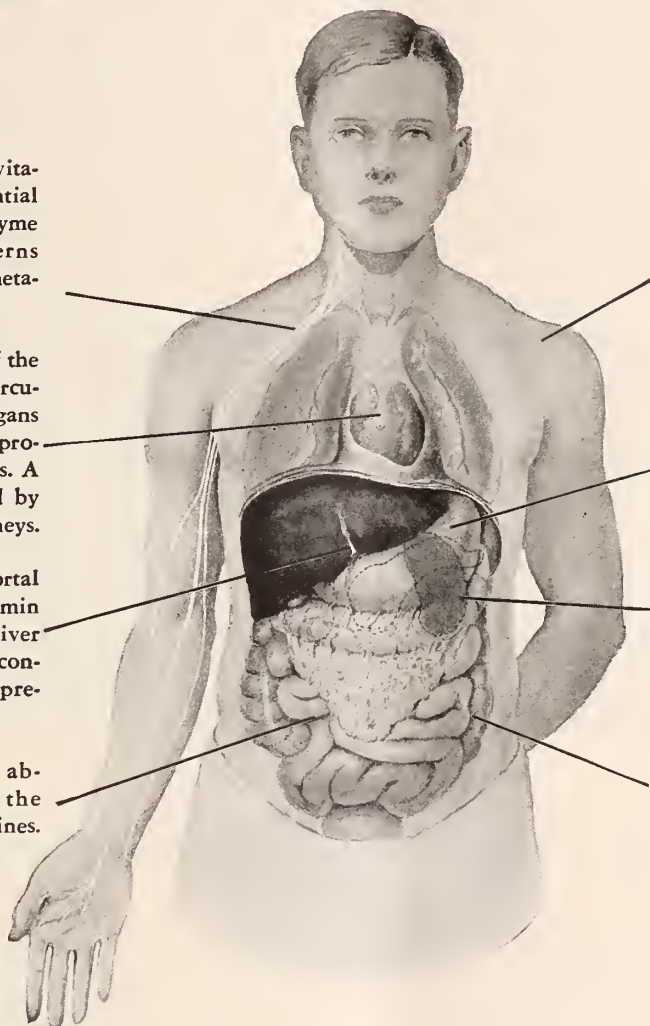
This page is the seventh of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the June 22 issue of The Journal of the American Medical Association.

(4) In nerve tissue, vitamin B₁ is an essential component of an enzyme system which governs one phase of the metabolic process.

(3) The remainder of the vitamin enters the circulation, the various organs removing thiamin in proportion to their needs. A large amount is used by heart, liver, and kidneys.

(2) By way of the portal circulation the vitamin is carried to the liver which under normal conditions retains an appreciable amount.

(1) Vitamin B₁ is absorbed from both the large and small intestines.



(5) In skeletal muscle, vitamin B₁ also forms a part of an essential enzyme system governing a phase of the oxidative process.

(6) The secretory and motor function of the stomach may be affected by involvement of the gastric nervous mechanism as a result of B₁ deficiency. This may account for the anorexia in this condition.

(7) If excessive quantities of vitamin B₁ are ingested and absorbed, they are not stored for future use but are excreted by the kidneys; during periods of diuresis considerable quantities of the vitamin may be lost.

(8) Vitamin B₁ found in the feces is largely the result of bacterial growth. Coprophagy provides a source of B₁ for some species of animals.

The Metabolic Fate of Vitamin B₁

In the tissues, vitamin B₁ is an essential part of an enzyme system governing one phase of cellular metabolism. Vitamin B₁ appears to be converted to co-carboxylase, which is essential for the oxidation of pyruvic acid, one of the intermediary products of carbohydrate metabolism.

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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

From an Original Article on "The Use of the Lane Plates in Fractures: Report of Forty-Eight Operations," by Fred R. Fairchild, M.D., Woodland.—Since the meeting of the Northern District Medical Society in Woodland one year ago, several of the members have done me the honor to suggest that they would like to hear further consideration of the paper, that I at that time read, on "The Open Treatment of Fractures, With Special Reference to the Use of the Lane Plates." I am the more ready to take the subject up again, since time prevented any discussion by the fellows present. Then I am glad of an opportunity to defend a method the results of which make me increasingly enthusiastic, while, at the same time I am aware that with many others, it is falling into disrepute. . . .

From an Original Article on "Gas Bacillus Infection," by Gilbert M. Barrett, M.D., San Francisco.—If one presents something before this learned body which boasts absolute novelty it may enjoy a hearing justified by its newness; if it is something old, trite and not in a new dress it has the advantage of old friendship; if it lies between these, being neither so rare that it is not met with, nor yet so common as to be threadbare, it merits at least the consideration accorded acquaintanceship if not friendship.

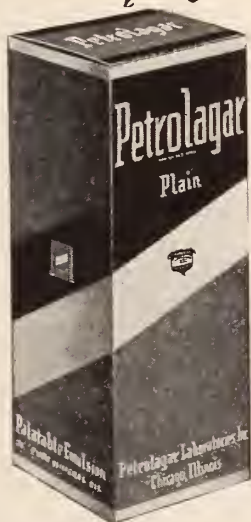
In bringing to your notice this subject of gas bacillus infection I have gone over the material previously reported in the literature so far as possible. . . .

From an Original Article on "Progress of Ophthalmology in the Year 1914," by Hans Barkan, M.D., San Francisco.—The review of progress in ophthalmology here-

(Continued on Page 30)



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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

with given will confine itself by space necessarily only to the most important new advances in diagnosis and treatment; by choice to those advances most likely to interest the general medical reader. In a specialty of as confined a therapeutic and operative scope as ophthalmology—one as old and in which for many years past a vast amount of work has collected—a year's advances and new facts established are limited. The last year has, however, brought out a few new ideas and has seen the practical working out and acceptance by the profession of some points in the debated ground of the years 1912-1913. . . .

From an Original Article on "Some Recent Studies in Gastric Secretion," by Robert Pollock, M. D., San Diego.—The advance along the line of our knowledge of gastric secretion has been somewhat intermittent; long periods of quiescence intervening between the few periods of active progress, which were of sufficient prominence to stand out in bold relief. Just such a period, however, we are passing through at the present time.

After accepting the results of any research worker as proven, we are very prone to consider them as final: and so long as they reasonably fulfill the requirements of our daily problems, we are content to believe that they leave nothing to be desired. . . .

From an Original Article on "Routine Examination of the Cerebrospinal Fluid in Suspected Syphilis of the Nervous System; Recent Modifications in The Preparation of Lange's Colloidal Gold Solution," by Thomas G. Inman,

M. D., San Francisco.—Investigation of the cerebrospinal fluid as an aid in the diagnosis of diseases of the central nervous system has, during the past ten years, assumed a position of the greatest importance. In not a few diseases a correct interpretation of the physical or chemical changes in that fluid, or the detection of a bacterial intruder, will determine the nature of the disorder in question with a degree of certainty not afforded by any other means at our command. Thus lumbar puncture has become almost a routine practice in the neurological examination. . . .

From an Original Article on "Autonomic Reflexes from the Digestive Tract," by Harry B. Reynolds, M. D., Palo Alto.—The progress made in diagnosis of diseases of the digestive tract in the last decade is little short of phenomenal. In the past our only avenues of approach were through the subjective history, a physical examination and laboratory studies. The work of Paulow and others working along lines of experimental physiology has formed anew our conceptions of the process of digestion. The studies of Cannon, Hertz, Meltzer and others have accumulated a mass of data on the motility of the digestive canal no less startling than the late discoveries on the heart beat. The Roentgen rays, experimentally and clinically applied, have amassed facts which bring us closer to absolute precision in our diagnosis. . . .

From an Original Article on "The Ring to Ring Incision for Herniorrhaphy," by Harry M. Sherman, M. D., San Francisco.—Training in the operating-room as assistant so familiarizes the young surgeon of today to the making and closing of incisions that the whole subject is dropped

(Continued in Back Advertising Section, Page 34)

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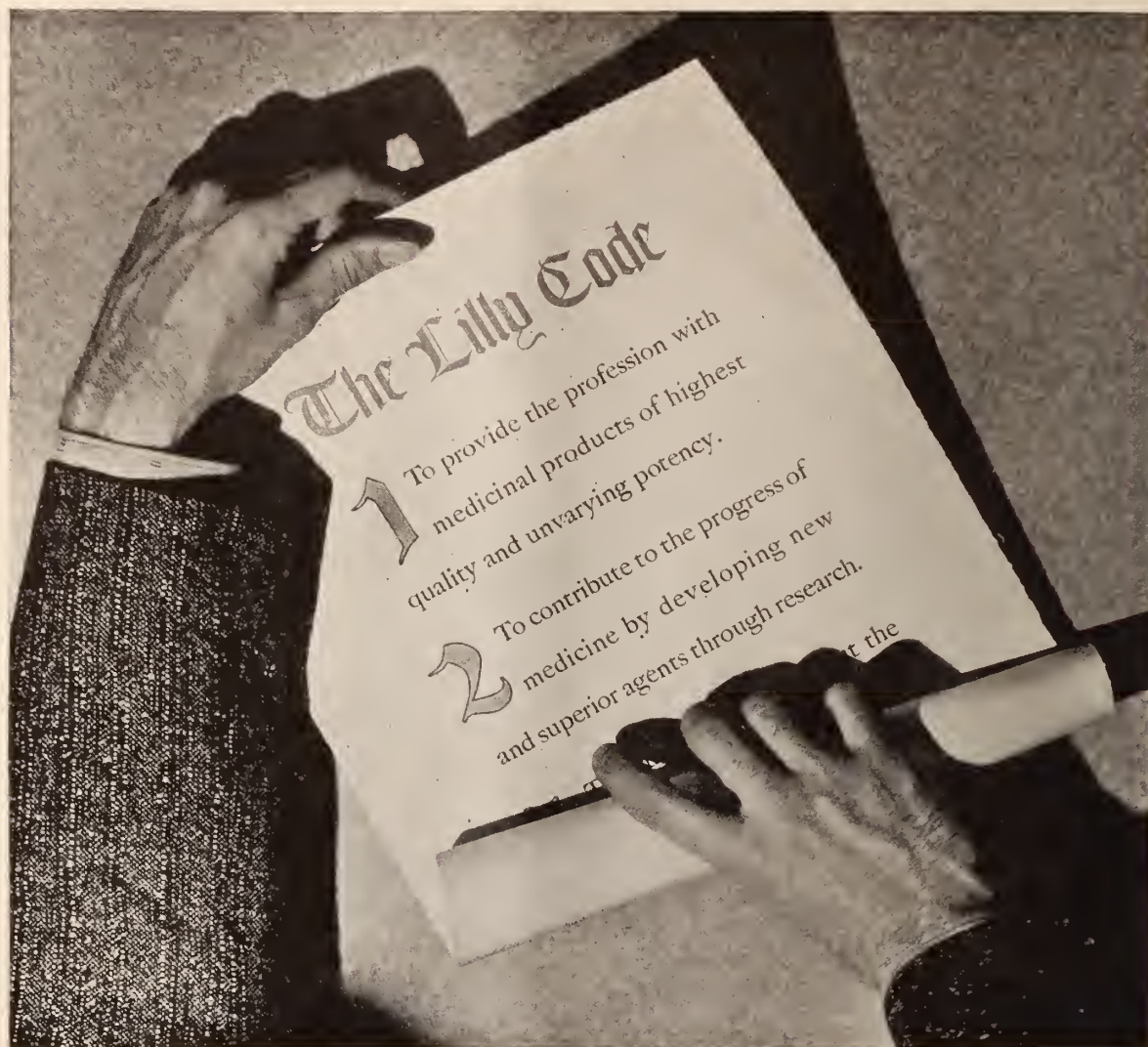
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CALIFORNIA AND WESTERN MEDICINE

OFFICIAL JOURNAL OF THE CALIFORNIA MEDICAL ASSOCIATION

VOL. 53

JULY, 1940

NO. I

California and Western Medicine

Owned and Published by the
CALIFORNIA MEDICAL ASSOCIATION

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Francis E. Toomey	San Diego	1942
G. W. Walker	Fresno	1943

Secretary-Editor, ex officio

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Advertising Representative for Northern California

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles; Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

"M" DAY: MEDICAL MOBILIZATION DAY

Action of the American Medical Association in New York.—In New York, at this year's annual session of the American Medical Association, on June 11, the House of Delegates of that national organization pledged the resources of the medical profession in full support of the military forces of the United States. So once again, within the brief span of one-quarter of a century, the making of preparations for a medical mobilization—a new "M" Day—will be experienced by more than one hundred thousand physicians. The offer of professional services, tendered on their behalf by the American Medical Association, will permit the Government to practically "enlist, distribute and regulate them (the medical profession) in time of war."

* * *

Important Rôle of the Medical Profession in Military Forces.—In the World War of 1914-1918 the medical profession rendered yeoman service of great value, and in the plans now under consideration by the Government the whole-hearted aid of physician-citizens is more than ever important. Indeed, it is no exaggeration to say that, in large measure, the efficiency of combat units depends upon the medical personnel of the army, navy and air forces; who, from the standpoint of preventive medicine, are called upon to keep the soldiers healthy and fit for service, through supervision of sanitation and food and other supplies, and also by the application of curative measures to conserve life, and to restore sick and injured soldiers and sailors for their duties as promptly as possible. Because of many factors, the procedures and methods so much in constant use in civil practice take on liberal modifications or radical changes, in order to make them adaptable and useful to military establishments.

* * *

Every Physician Should Be Alert in These Matters.—Since policies already approved by the constituted authorities of our country are bringing into being a military establishment different from any that has ever existed in the United States

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

in the past, and because services of the medical profession are of vital importance to the armed forces, it behooves every physician promptly to prepare himself for the part he may be called upon to take in these new responsibilities which face him in both his civil and professional capacities.

The *Journal of the American Medical Association*, in its reports of the proceedings of the national House of Delegates, will give additional information concerning the actions recently taken in New York.* The Council of the California Medical Association meets on June 29, when this and related matters will receive their careful consideration. In the meantime, members of the Association should give careful thought to these issues that, as each week passes by, are thrusting themselves before the people of America with increasing importance and insistence. In all this, the record of the medical profession must not only be above reproach, but of a nature to let every physician take pride therein. Indeed, here is an opportunity that may offer possibilities for the early reestablishment of the prestige of the medical profession, which, in recent years, has been so grossly and unjustly assaulted by forces aligned with certain groups militantly engaged in efforts to inflict Bismarckian compulsory health systems on some of the states of the Union.

CALIFORNIA POSTGRADUATE ACTIVITIES

Agitation for Postgraduate Conference Bringing Results.—During the past several years, the California Medical Association Committee on Postgraduate Activities has striven to enthuse the component county societies with a desire to institute postgraduate conferences in their respective districts, and in 1939 these efforts were rewarded with considerable success. However, the responses received on participation in the postgraduate programs have been far from satisfactory. Gratifying, however, has been the knowledge that county units, whose members have taken up the work in earnest, have become its staunchest supporters. This desire for repeat courses is in accord with the experience of postgraduate committees in other states, and is a tribute to the value of such conferences.

* * *

Basic Problems in Postgraduate Conferences. California covers an extensive geographical area, with population centers scattered in much more irregular fashion than in some of the states east of the Mississippi, where postgraduate courses have been promoted. On that account, transportation expenses of guest speakers are considerably higher, a financial fact that cannot be evaded by either the State or local postgraduate committees.

In the inauguration of clinical conferences, one of the real difficulties is to secure an enthusiastic,

hard-working and able committeeman, or committee, who will accept the responsibility of making local arrangements, and of being constantly on the job until the outlined program has been carried through in successful fashion.

The personnel of the local committee on postgraduate, clinical, or refresher courses, therefore, is an item of importance. The chairman of such a committee must be a physician who is willing to give whole-heartedly of his time and effort, not only to indicate what guest speakers and courses are desired, but also to create real interest in, and attendance at, all meetings.

* * *

Plans for Fall Clinical Conferences Should Be Made.—If, then, postgraduate conferences are to be carried through with success during the coming autumn, plans should be taken up at the present time, so that arrangements mutually satisfactory to all parties interested may be gotten into form.

Component county societies, through their officers or committees on postgraduate work, should feel free to communicate with the headquarters office of the Association, indicating wishes regarding prospective courses to be given during the fall and winter months.

* * *

Postgraduate Conferences in Metropolitan Centers.—Concerning conferences in the cities of San Francisco and Los Angeles, the suggestion has been made that twice a year, in each of the two cities, a one or two-day refresher course might be offered, with clinical work and presentation of patients in the respective county hospitals. Such courses could be conducted under the auspices of the attending staffs of the four medical schools, the two institutions in each city alternating in the giving of spring and fall courses. Such an arrangement—which in modified form has been put in operation elsewhere—creates an opportunity for physicians who have neither the time nor interest to register in the annual sessions of the State Medical Association, and gives such members an opportunity to meet one another and to profit from attendance at the clinical presentations. It has been pointed out that the use of the teaching facilities of county hospitals in this manner will fulfill a need of physicians in both the local metropolitan areas and in adjacent or more distant parts of the State.

The California Medical Association Committee on Postgraduate Activities, which may be addressed through the central office of the Association, at 450 Sutter Street, San Francisco, will be happy to receive comments on any of these matters.

PROPOSED RESEARCH BY THE UNITED STATES PUBLIC HEALTH SERVICE

Legislation Worthy of Approval.—Recently submitted to the United States Senate was a proposed law (S. 3914) which would "impose additional duties upon the United States Public Health

* To carry out the instructions of the House of Delegates, a Committee on "Medical Preparedness" was appointed. The Pacific States are represented thereon by Dr. Charles A. Dukes of Oakland, and Dr. John H. O'Shea of Spokane, Washington. Further information in regard thereto may be found in *The Journal of the American Medical Association*, June 22, 1940, on page 2466.

Service in connection with investigation and control of pneumonia, influenza and the common cold."

The printed report of recent hearings before a subcommittee of the Committee on Education and Labor of the United States Senate, under the chairmanship of Senator Claude Pepper of Florida, gives the testimony submitted by a group of physicians who had been invited to appear and express their opinions: (1) on the need of the studies referred to; (2) the amount of funds to be allotted therefor; and (3) as to whether the work could be carried on to best advantage as one of the investigation activities of the United States Public Health Service.

Among the well-known physicians who appeared before the Subcommittee were the following: Dr. Thomas Parran, Surgeon-General, United States Public Health Service; Dr. Walter Bierring, Commissioner of Health, State of Iowa; Dr. John J. Shaw, Secretary of Health, Commonwealth of Pennsylvania; Dr. H. A. Holle, National Institute of Health; Dr. Russell L. Cecil, Professor of Clinical Medicine, Cornell University Medical College of New York City; Dr. Jesse M. Bullowa, Clinical Professor of Medicine, New York College of Medicine; Dr. Julien E. Benjamin, Associate Professor of Medicine, University of Cincinnati.

* * *

Appropriation Would Be for \$3,000,000.—For the fiscal year ending June 30, 1941, S. 3914 would appropriate a sum, not to exceed \$3,000,000. At the present time, the United States Public Health Service has available for annual use, in the studies contemplated, not more than \$35,000—an amount totally inadequate, when the losses to the country, which result from illness and deaths that could be prevented, are taken into consideration.

The report also gives interesting information on not only the three diseases immediately concerned, but also on other research activities of the United States Public Health Service, as well as those of its sponsored subsidiary, the National Institute of Health. Perusal of the minutes of the hearings is of special interest because of the pertinent queries put by Senator Pepper, and of the placing in the record of certain facts concerning the influenza pandemics of 1888 and 1918; the pneumonia control work with sera in the states of Massachusetts, New York, and Pennsylvania; and the newer procedures in chemotherapy, with special relation to sulfanilamide and sulapyridin.

* * *

Mortality Rates.—The pneumonia and influenza death rates per one hundred thousand are given for the different states, Arizona having a rate of 199.8, as against California's 82.7. Influenza is counted with pneumonia because "an influenza death is a pneumonia death."

In a table on the incidence of pneumonia (all forms) and influenza, California was credited with 4,281 deaths in 1938, and 3,298 in 1939, the ten-year average, period of 1929-38, being 5,006. The death rate per 100,000 population for the five-year

average, 1934-38, was 82.7. In the influenza pandemic of 1918 the death rate from that disease in the United States rose from the then average of about one hundred fifty per 100,000 to almost six hundred.

* * *

Manner in Which the Studies Would Be Made.—Surgeon-General Parran, in answering the question on what he thought the proposed law would do, stated:

In the first place, the Public Health Service has had long experience in dealing with the states in regard to a number of health problems, both the general problems of health, under Title VI of the Social Security Act, the recent Venereal Disease Control Act, and, to a small extent, the National Cancer Institute Act. We already have the machinery to carry out this additional grant-in-aid program. Very little additional overhead would be necessary, because we have our district officers, and we have representatives in the several parts of the country who are already available to help carry out this program. We need some additional technical people, of course, people who have the technical ability of Doctor Holle, Doctor Ruemrich, and others who were here this morning. The overhead is already taken care of. That is the first point. The machinery for dealing with the states in comparable matters has already been set up. I will state if this bill is enacted we will call a conference of the State health officers to discuss with them the provisions of the regulations which are authorized under the bill. That procedure is traditional in any dealing with the State authorities, so that there is mutual agreement as to the weight which should be given to each of the several factors mentioned in the bill.

The bill provides that the funds should be allotted on the basis of population, the extent of the pneumonia problem, which is determined by the death rate, and the financial needs of the respective states. So the yardstick is already created in dealing with such a matter as this. The only question is the relative weight to be given to each of the three problems.

* * *

How the Venereal Disease Program Has Been Carried On.—Concerning the venereal disease program and the extent to which different commonwealths have responded with State funds, Doctor Parran went on to say:

Doctor Parran: While I am not entirely satisfied with the progress we have made, the program is well ahead of schedule. In general, the states have done their part. They have put up more than \$2.00 for every dollar of Federal money which has been allotted to them. The appropriation this year is \$5,000,000. Of that, about a half-million is used by the Public Health Service for its research and administration, the remainder has been allotted to the states.

Senator Pepper: You set up certain standards of matching. I think you said on an average they put up \$2.00 to \$1.00 of Federal money.

Doctor Parran: Yes. The states in turn allot the money to the localities for the establishment of the treatment, the diagnosis and treatment facilities. In a comparable way under this bill states would allot the money to local departments of health, to be used in the ways that Doctor Holle has described. There is a basic consistency between the provisions of this bill and those of the Venereal Disease Act in that in each case an important objective is to put better tools in the hands of the practicing physician. In that connection, Senator Murray, that action supplements the provisions of the pending hospital bill under which community hospitals would be built.

Here is another example of enabling doctors to practice scientific medicine, by supplying them with the costly laboratory service, costly drugs and serum for their poor patients, and also the provision of nursing care, because so often the difference between life and death of the pneumonia patient depends on good nursing.

Medical Profession Has Given Full Coöperation.—The following should, likewise, be of interest:

Senator Pepper: Doctor, what has been the attitude of the medical profession toward the cancer and venereal disease programs?

Doctor Parran: There has been the fullest possible coöperation in respect to both of them, and, with your permission, I should like to put into the record a quotation from an address by the President-Elect of the American Medical Association, given in Chicago at the National Social Hygiene meeting, February, 1940, in which he expressed that coöperation, and also pledged coöperation for the President's hospital construction program.

Senator Pepper: We would be glad to have the statement put into the record. (The statement referred to is as follows):

In the *Journal of Social Hygiene*, Volume 26, No. 3, March, 1940, speaking of the venereal disease control program, Dr. Van Etten said: "I can assure him (Doctor Parran) that the American Medical Association will be heartily coöperative, because it cherishes the same ideals."

In reference to pending hospital legislation, Dr. Van Etten stated: "The new proposal of the President may carry new hospitals and laboratory facilities to places where they are needed, and prove a great source of help in regions where the progress of social diseases are unchecked and untreated. The President should receive the hearty support of all physicians in this new project."

* * *

On What It Is Believed the Proposed Law Would Accomplish.—These comments may be closed with a quotation regarding the type of service to be rendered through the proposed law:

Senator Pepper: State what kind of program could be put into effect in the country if this bill were passed.

What results do you think, based upon your previous experience and knowledge, would be obtainable with this program in effect?

Doctor Holle: I believe it calls for \$3,000,000 for the first fiscal year. It would enable every state to establish a pneumonia control program, it would enable them to have trained personnel—one or more—medical men trained in pneumonia, laboratory people trained in pneumonia who would go around in the state and assist the private laboratories to develop high standards, or to keep their standards of diagnosis, through laboratory work in the pneumonia field, at a very high level through check testing and other technical assistance. It would enable the physician to receive, for every pneumonia case, at least, sulfapyridine. I cannot give you the figures on whether it would be enough to supply serum in every case in which it was needed, or whether it would be enough to provide hospitalization for any of the pneumonia cases or not; but at least you could give them the minimum essentials of sulfapyridine and perhaps serum, and laboratory services, and we hope limited amounts of nursing services; visits of public health nurses into the homes to assist the people by instructing them under the doctor's direction on how to take care of the patient, how to take the specimens, how to administer the drug to the patient under the doctor's direction; principally, to strengthen the laboratories, to subsidize private laboratories for having done work on these patients in areas where no public laboratory exists. It is not right for the doctor continually to call upon the private laboratory to do work free when there are no funds available for reimbursing them.

* * *

The brochure of sixty-two pages, containing the report referred to, bears the number 231,749, in publications of the United States Government Printing Office, Washington. If request be made to the Honorable Claude Pepper, United States Senator from Florida, or to the United States Government Printing Office, stating the number of the report, a copy will probably be sent to any physician so applying.

ON VARIOUS TOPICS

American Medical Association Will Meet in San Francisco in 1943.—In New York, on June 11, the House of Delegates of the American Medical Association, by a vote of 94 to 50, accepted the invitation of the California Medical Association to hold the American Medical Association session of the year 1943 in San Francisco. California entered the race at a rather late day, but in spite of that handicap was successful over Detroit and St. Louis; and, appreciating the compliment, Californians will do their utmost to make the meeting measure up to the best standards of the past.

* * *

Reapportionment of American Medical Association House of Delegates.—The increasing membership of the California Medical Association will permit California hereafter to be represented in the American Medical Association House of Delegates by eight instead of seven delegates. New York, Pennsylvania, and Illinois are the three states which have larger delegations.

* * *

Hearings on the American Medical Association Indictments.—It is rather curious that the officers of the American Medical Association should have been called upon to immediately leave the New York annual session on June 14 to personally appear in Washington, D. C., and submit their pleas in the suits sponsored by the Government, in connection with its contention that the Sherman anti-trust law had been violated in the Group Health Association controversy. Keeping in mind some past activities having to do with this suit, one is almost tempted to think that the date of the hearing was set with plans aforethought.

* * *

California Physicians' Service.—California Medical Association's solution of the problem of providing medical service to meet the needs of citizens belonging to certain income bracket groups, is given expression in California Physicians' Service, a nonprofit corporation whose professional membership is made up almost entirely of physicians who are members of the State Medical Association.

In this issue, on page 37, is a progress report that should be read by all California Medical Association members. In connection therewith, time may also be taken to read the discussion on Resolution No. 7, in the June issue of CALIFORNIA AND WESTERN MEDICINE (page 283), and other comment on acquisition and related problems of California Physicians' Service (page 291), as presented at the annual session in Coronado.

* * *

"God Bless America and Preserve Our Priceless Heritage."—Such was the half-page illuminated caption in a full two-page illustrated advertisement by the "National Physicians Committee for the Extension of Medical Service,"* appear-

*Articles concerning National Physicians Committee have appeared in former issues of CALIFORNIA AND WESTERN MEDICINE, as follows: In December 1939, pages 358 and 360 (Achilles Heel); and March 1940, page 120 (Minute Men).

ing on pages 62-63 of the *Saturday Evening Post*, in its issue of June 22, 1940. Physicians who have not seen the above announcement would do well to secure a copy of the publication. The statement of the National Physicians Committee (N. P. C.) was presented in excellent manner, and the medical profession of the United States is under obligation for this splendid expression of educational endeavor through which an important message was called to the attention of the people of the United States. Especially physicians who have felt that the profession has been laggard in presenting its side of current medical service issues should read the National Physicians Committee advertisement. At its bottom was printed, "Contributions from physicians from nearly every county of every state paid for this advertisement."

* * *

Medical Legislation on the November Ballot. Compulsory Health Law: Present signs indicate that the much-discussed compulsory health legislation will not be submitted to the voters of California at the coming state election in November.† That does not mean, however, that it may not be thrust to the front at the next session of the Legislature, which will convene in Sacramento in January, 1941. Members of the medical profession, therefore, should keep in mind that good citizenship necessitates interest concerning persons who are candidates as State senators or assemblymen; for it is the State legislators who will sit in judgment on these important proposed statutes. Hence, support should be given only to such nominees as are known to have sound views on public health needs.

Basic Science Law: Concerning a basic science initiative, some of the difficulties in connection therewith were indicated in the discussions at meetings of the House of Delegates at Coronado, and recorded in the session minutes. (See June issue of *CALIFORNIA AND WESTERN MEDICINE*, on page 286.) The proposed legislation remains a subject of study, and will be sure to receive the earnest attention of the Council.

* * *

Cancer Exhibit at Golden Gate Exposition.—The exhibit planned by the California Medical Association Cancer Commission and displayed last year at the Golden Gate International Exposition has been reinstalled for the 1940 Fair, where it is housed in the Science Building. Members of the Association may wish to inspect the charts; and suggestions for any improvements will be welcome.

* * *

Wagner-George Hospital Construction Bill (S. 3230).—The much-debated federal measure known as the Wagner-George Hospital Construction Bill, which was sponsored by President Roosevelt, has received the favorable vote of the Senate and, as revised, is now before the House of Representatives for consideration. Fortunately, some of

the defects so evident in the original draft have been remedied. In its present form, the proposed law would allot to the United States Public Health Service, for a period of six years, beginning June 30, 1941, an annual appropriation of \$10,000,000, said sum to be available not only for construction, but for maintenance of the hospitals authorized for erection, or for grants-in-aid.

Under Plan I of the measure, a local community, through the State Director of Public Health, would file its application, showing therein why a real need for a hospital exists in its area, and guaranteeing both that means would be provided to make the facilities widely available, and also that equipment and facilities would be maintained according to the standards laid down by the governmental authorities.

The hospital would be leased to the community for a period of sixty consecutive months, and at the end of that period the property would be transferred to the lessees.

Plan II would be of a type of grant-in-aid, the Federal allocation to a community to vary from 25 to 90 per cent of the total cost of the hospital to be constructed. In these grant-in-aid hospitals, the title would be vested in the community from the beginning.

If the proposed law receives the approval of the House of Representatives and the signature of President Roosevelt, it will be possible for certain communities to make available for themselves hospital facilities now lacking and needed.

* * *

Dr. Hugh Cabot's "The Patient's Dilemma."

This is the title of a volume from the pen of a well-known physician which has been the subject of much discussion, some of the author's positive statements receiving considerable criticism. It may be of interest, therefore, to readers to note the reactions aroused through perusal of Cabot's book, as evidenced in comments in recent medical publications.

An editorial in the *North Carolina Medical Journal* of June, 1940, for example, has this:

In his recent book, *The Patient's Dilemma*, Dr. Hugh Cabot quotes the following statement from Dr. Morris Fishbein: "Obviously, 85 per cent of the diseases for which patients consult doctors are of the type which the general practitioner can handle with the amount of equipment that he can carry in a handbag." Doctor Cabot's comment is, "We shall, I think, be on sound ground in asserting that this statement never was true and that it is even less true today. . . . I am unaware of any evidence . . . acceptable to any scientific body which would support Doctor Fishbein's allegation."

In an effort to find out which of these views was correct, five Winston-Salem, North Carolina, medical men tabulated an average of two hundred consecutive cases each. Of the one thousand patients thus reviewed, 848—or 84.8 per cent—had been cared for without any other equipment than the contents of a handbag. A modern doctor's handbag, be it remembered, contains at least a blood pressure apparatus, a stethoscope, a hypodermic syringe, an otoscope, an ophthalmoscope, a transillumination light, a blood counting apparatus, glass slides, a hemoglobin scale, a pleximeter, tongue depressors, Wassermann tubes, culture tubes, and a few other odds and ends. . . .

The lowest proportion of patients cared for unaided by an individual doctor was 82 per cent; the highest, 89. The

† Since this was written, press dispatches have stated that a compulsory health initiative would not have a place on the November, 1940, ballot.

average of 84.8 per cent is certainly close enough to 85 to be acceptable to most scientific bodies as supporting Doctor Fishbein's statement.

* * *

And in *The Journal of the Maine Medical Association* of June, Dr. R. Bliss of Bluehill writes:

Passing strange and entirely regrettable is the inclination of the retired physician to wield the devastating pen when nearly every country in the world offers such opportunities for the less deadly sword. Dr. Hugh Cabot, retired from a life profoundly influenced by the Mayo Clinic, has felt constrained to write a book, "The Patient's Dilemma." . . .

As might be expected, the author's experience and environment have led him to exalt the group clinic which he knows so well and to charge the physicians of small villages, of whom he obviously knows nothing, with abysmal ignorance. . . .

When the country physician calls upon a middle-aged patient who has never been clinic serviced, he immediately forwards the patient to the nearest clinic where a group of specialists mill him through and give to him, or sell to him, "a good article" of medical care. The physicians of the small towns and villages will be expected to attend short, simple illnesses and send all others to the regional clinic. These country doctors are to be keen, well educated young men who, by frequent courses in the great clinical centers, continue to be good diagnosticians surcharged with good old country doctor qualities and yet content, year after year, to act in their capacity as transfer agents for the clinical centers. Just what vitamin is to be fed them to produce this bovine contentment is not revealed in Doctor Cabot's book. . . .

That an able surgeon, stepping down from a trail pure and white with notable achievement, should deliberately seek to blacken and smear the road over which the next generation of young men must travel, at least illustrates another way of bearing up under the strain of retirement.

No penalty is severe enough for the unclean bird who literally befouls his own nest.

* * *

However, snap judgment should not be made. Physicians who are interested in these problems may well take the time to read Doctor Cabot's book, and then form their own conclusions concerning his breadth of view and the value of his criticisms and suggestions.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 36.

EDITORIAL COMMENT†

TOXIN FROM SUPERFICIAL BURNS

Wense,¹ of the Institute for Experimental Pathology in the University of Innsbruck, currently reports that animals immune to histamin are not resistant to the autotoxin produced by superficial burns. From this he concludes that histamin plays

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Wense, Theodore: *Zeitschr. f. Immunitätsforsch.*, 97:100 (Nov.), 1939.

but a minor rôle in the autointoxication following local heat injury.

The shock and early death which follow superficial burns are presumed to be due to autointoxication. This concept has apparently been long established. Aqueous extracts of skin from burned areas are highly toxic for experimental animals. Transplantations of skin and establishment of circulation between normal animals and those superficially burned transfer the toxin. Earlier attempts to identify the toxic agent, however, led to the generally accepted conclusion that the toxic factor is probably not a heat-denatured normal protein, but some fairly simple, nonantigenic protein split product. Attention was soon centered on histamin as the probable factor, this substance being present in relatively large amounts in burned skin and in the blood of experimentally burned animals.

The fact that laboratory animals can be rendered highly refractory, or relatively "immune," to histamin, suggested to Wense a practical method of testing this conclusion. In his experiments guinea pigs were given daily subcutaneous injections of histamin for a period of about two weeks, at the end of which time the animals were able to tolerate forty to sixty times the usual lethal dose of histamin. These histamin-refractory animals were then tested for their relative susceptibility to superficial burns. Large skin areas of normal control animals under ether anesthesia were dipped for two to two and one-half minutes into hot water (80 degrees centigrade). Animals with this degree of scalding usually developed profound shock, from which death resulted in about two hours. A shorter immersion (one-half to one minute) usually caused little or no shock, but death usually resulted in from one to three days. No appreciable changes in this normal symptomatology or fatality rates were observed in parallel test with the guinea pigs immune to histamin. Indeed, the histamin-immune animals seemed slightly more susceptible to superficial burns than the normal controls. The conclusion seems inevitable that histamin is not the essential autotoxic factor.

Wense confirmed this conclusion by therapeutic tests with the histamin-destroying intestinal ferment ("torantil") recently isolated by European biochemists.² This intestinal enzyme injected intravenously will protect laboratory animals from multilethal doses of histamin. In Wense's hand, however, the enzyme had no demonstrable therapeutic effect in the autointoxication following superficial burns.

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HAZARDS OF PATCH TESTING

Patch tests, to be of value, must be properly interpreted. When considered in the light of the patient's history, however, such tests are of prime importance in the study of both contact dermatitis

² Rigler, R.: *Münch. med. Wschr.*, 1:15, 1936.

and exfoliative dermatitis. Such tests are of little or no value in other types of cutaneous manifestations. It must be remembered, though, that the application of an allergen or hapten to the skin is not without danger.

Primary irritants, as exemplified by undiluted gasoline, may produce an area of necrosis leading to a sluggishly healing ulcer and unsightly scarring. The victim of such a reaction is seldom grateful to the physician applying such a test. For this reason, articles such as that of Rostenberg and Sulzberger,¹ giving the strengths of substances which are non-irritating, should be in the possession of every practitioner who performs skin tests.

A second type of disconcerting reaction is the generalization of a previously localized eruption following the application of a patch test. This is especially true in preëxfoliative arsenical dermatitis,² where a mild pruritic eczematoïd patch may assume the alarming aspect of a true edematous desquamative exanthem. In one case, in my experience, the application of a 10 per cent cocain ointment produced a generalized morbilliform eruption.

Patch testing may lead to sensitization of previously uninvolved skin. A healed patch test on the arm, for instance, may exhibit activity in recurrent eruptions which were previously confined to the hands.

The fourth, and most serious complication, is the development of constitutional symptoms following the application of a contact test. In one case under my care, the application of a nicotine-containing plant spray to the unbroken skin of the patient's back resulted in a severe attack of nausea and vomiting, occurring within fifteen minutes after the test had been put on. Despite the immediate removal of the test, and the thorough cleansing of the patient's back, this episode lasted for more than two hours. It was accompanied by marked pallor. The patient, who was sixty years of age, had never used tobacco in any form during his lifetime.

Therefore, it is obvious that one should consider all these factors before adopting a routine of indiscriminate patch testing of all patients exhibiting sensitization dermatoses.

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Oakland.

METHOD OF TREATMENT OF TRICHOMONAS VAGINALIS VAGINITIS

It is not the purpose of this brief paper to consider whether the trichomonad is a contaminant, is in symbiosis, or is the cause of the typical vaginitis in which it is found, but to report a method of treatment. This particular technique of treatment, in the hands of certain of my associates and myself, has uniformly produced prompt and oftentimes spectacular cure. In fact, one or two applications will not infrequently produce apparent

cure in cases which have for months stubbornly resisted many other methods and agents of treatment. In addition, it is simple, not costly, and lacks the discomfort to the patient of certain of the more drastic cleansing procedures. No local or general evidences of toxic effect have been noted, as have occasionally been reported from other materials.

An ordinary bivalve speculum is used and the vault of the vagina exposed. All easily removed mucus and secretion are wiped free with cotton swabs. Caroid powder is then applied by applicators to the cervical canal and upper vagina. It is used liberally, and sufficient time is allowed to elapse for all of the tenacious secretion and mucus to be liquefied or freed. Ordinarily one or two minutes are adequate. All this residue of powder and liquefied secretion is then carefully wiped out of the cervical canal and vagina, rotating the speculum as necessary. This operation, properly carried out, leaves the cervical and vaginal mucosa clean and dry.

The treatment is then completed by the application of 20 per cent aqueous solution of mercurochrome. Lesser concentrations of this drug do not have as rapid an effect, and do not leave the vaginal tract as dry. A tightly wound applicator, saturated in this solution, is first placed in the cervical canal and is allowed to remain *in situ* until the treatment is completed. The entire cervix and vagina are then carefully painted with the mercurochrome solution, rotating the speculum as needed to cover every portion of the surface. The speculum is withdrawn and finally the applicator in the cervix removed. Inasmuch as the mercurochrome solution stains clothing badly, it is wise to place a cotton plug or tampon in the lower vagina after the treatment.

These patients are usually treated twice weekly; and, while one treatment will frequently produce an apparent cure, we feel it is wise to use three or four applications. We then follow with one treatment after each menstrual period for two or three months, which greatly reduces the possibility of recurrence. The patients who have recurrences are further advised. Careful instruction is given in the method of cleansing after defecation; they are prohibited from using the standard sanitary napkin and are instructed to use menstrual tampons, and, if the vulvar and perineal hair is profuse, they are advised to keep the area shaved. Recurrence, in spite of these precautions, necessitates investigation of the sexual partner for the possibility of a trichomonas infection of the urethra or prostate.

SUMMARY

1. A simple and extremely efficacious method of treatment of trichomoniasis is presented.
2. The prevention of recurrences is briefly discussed.

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¹ Rostenberg, Adolph, Jr., and Sulzberger, Marion B.: A List of Substances for Patch-Testing and the Concentrations to Be Employed, *J. Invest. Dermat.*, 2:93, (June), 1939.

² Epstein, Ervin: Sensitivity to Both Trivalent and Pentavalent Arsenicals, *Arch. Dermat. and Syph.*, 36:964 (Nov.), 1937.

There is no reason for tuberculosis to be five times more prevalent in some communities than it is in others.—Thomas Parran, M. D., U. S. P. H. S.

ORIGINAL ARTICLES

BIOLOGICAL ENGINEERS*

By RAY LYMAN WILBUR, M. D.
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TWO great streams of life—those of the plant and the animal world—surround and engulf man, who is but a part of them. Without the sacred power of reproduction, life in its relationship to time would be represented by the California redwood, or perhaps some of the molluscs of the deep sea. To control reproduction gives control of life. Much of our modern agriculture, with its consequent enlarged food supply that has increased human beings by billions, comes from invention and discovery and a better understanding of life processes and of reproduction. Civilized man is dealing in new and artificial ways with these life processes.

The physician is becoming a biological engineer serving the individual and society in many fresh and some rather startling ways. He can no longer be symbolized by pills and scalpels. His range of activity has become world-wide. His power for good or evil has become of vast significance. While the civilized world is witnessing various more or less effective efforts to control human fertilization, it is not beyond the possibilities that the scientist physician may actually acquire domination over human reproduction through new knowledge of hormones. This power could be used to cut off all of the weak channels from which our poorest stock comes; but it could also be used to the destruction of the race. We have no guarantees of a future free from extinction. The dinosaur did well for millions of years. At any rate we are in for a period of adjustment to reduced birth rates and to a sharp rise in the percentage of the old in our population.

The amazing advance in the application of chemistry and physics to biological processes is revolutionizing medicine in these very days in which we live. Within fifty years we have seen an almost complete transformation in the activities of the medical practitioner. Fifty years ago his functions were largely determined by observation and experience, and the books from which he got his education had much to do with description and comparatively little with experimentation. In half a century, experimentation and analysis have been brought in at such a rapid rate that at times we almost forget that over the centuries medicine was largely based upon shrewd observation and the accumulation and digestion of past experiences.

This development in medicine has run parallel to similar changes in that broad field of science which we have called biology. The practice of medicine is a form of applied biology. One can hardly fail to see life as a resultant of a combination of certain chemical substances that have some magic turn that gives them the power of change and reproduction. As our knowledge of the different

forms of life about us, including bacteria and viruses as well as insects and protozoa, increases, our skill in controlling the diseases caused by parasites has grown. In our battle against them we have sought for any means that would destroy them either in or outside of the body. In chemistry we have at times found the ideal procedure. The development of remedies such as quinine for malaria and salvarsan or its derivatives for syphilis, are good examples. We have vastly enlarged our capacity for the control of parasites through our knowledge of immunity and our studies of the abilities of living organisms to interfere with the growth of other living things within their own structure. In recent years physics has been added to chemistry as a fundamental part of medical research and care. Roentgen rays, radium emanations, and other forms of energy displaying themselves as waves, have been brought into day to day use.

Certainly we need to know as much as possible not only about the various forms of life from which we derive our food and growth, but especially those forms that live in or on us and cause disease. A knowledge of their biology has become vital. We are now treating the unicellular organisms in our laboratories just the way we do chemical substances in order to determine all of their possible reactions to external influence and chemical agents. In this way we may gain new points of view of value to medicine.

In our studies of the chemistry of the body and the cells which make it up, we will have to include now the use in considerable volume, by large numbers of our people, of alcohol, various anesthetics and analgesic drugs, narcotics, hypnotics, caffeine, nicotin, and in various parts of the world, betel nut and cocaine. With the help of advertising, we are spreading the use of many of these drugs over the whole human family without any very clear idea of just what may be the ultimate effect. It may be all right from the standpoint of sequence to advertise the use of some special coffee and a peculiarly fine "Slumber Right" mattress, but the combination may not be an ideal one from the standpoint of sound sleep.

We are just beginning to grasp some of the implications, chemical and otherwise, of fatigue—to realize that fatigue may involve some parts of the body more than others, and that mass fatigue of a people may have a good deal to do with infections and certainly a great deal to do with human reactions to unexpected strain. We have found some short cuts to relieving fatigue by the use of glucose solutions, and have found some drugs that will stimulate the nervous system and put it into different gear for a short time. We are learning something of the chemistry of fatigue.

The days have grown longer for our youth. For untold generations our relationships to light have been well established by the places in which we have happened to live and by the rising and setting of the sun. Now, with artificial light so widespread that sports can be conducted at night, with night turned into day in many ways, we may be developing profound effects from a biological standpoint

* Guest speaker's address. Given at the second general meeting of the California Medical Association at its sixty-ninth annual session, Coronado, May 6-9, 1940.

which will appear later. Fatigue, longer periods of light, widespread use of drugs, may counterbalance the advantages we have from our new knowledge of nutrition.

Nutrition and diet can no longer be associated with certain fads and fancies, but must be viewed in a realistic manner. An enormous amount of time has been spent by engineers upon the study of the fuels which provide the power for mechanical engines. The human engine needs even greater care. If a few decades ago somebody had proposed to sell concentrated milk that had been passed through certain waves of radiation, it would certainly have looked like a quack affair. We have discovered that there are various rays that can be developed by purely artificial procedures that are of great importance in nutrition. Physics has compelled us to think in entirely new therapeutic terms. Waves, too, have given us new knowledge of living human anatomy and through the roentgen ray have changed all of our procedures in the matter of injuries, have enormously increased our capacity for diagnosis and reduced the necessity for the elaborate studies of anatomy by dissection for those physicians who do not plan to operate.

The biology of the vitamins, the relationship of the sex organs and various enzymes, the oxidation reduction phenomena, are apparently of great significance; but we know but little about them and we need to be much better informed as to the effect of the emotions upon the glandular system of the body, particularly the various endocrine effects that we know have a profound effect upon our physiology.

In our biological engineering we will have to pay careful attention to the differences in the human engine during the period of babyhood, childhood, adolescence, maturity, and old age. With the constantly increasing percentages of elderly people in the population, and with the steady improvement of preventive medicine, more and more of the doctor's time will be taken up by those who have started down hill, from the standpoint of body perfection.

New perils have come into the world with the developments in intercommunication and with the widened influence of single individuals. The state of the blood vessels in the brain of a president, the percentage of sugar in the blood of a prime minister, the height of blood pressure in a general, may have a profound influence upon decisions involving millions, if not hundreds of millions, of people. Beyond this, the mental state of those who have achieved, acquired or have been given leadership may be of profound importance. There is a great deal that we will have to learn not only about growth, but about decline.

The physician who is to act as a biological engineer has not only the problem of living with his own central nervous system, but also that of dealing with others who have not found it easy to carry around a brain and a spinal cord with all of their connections and associations. Sometimes the doctor is able by various devices to make suggestions, perhaps supply vitamins or bring about a process that makes the human engine work a little better,

just as certain chemical constituents take the knock out of gasoline.

With the distribution of citrus fruits and other vitamin containing foods over many parts of the world throughout the year to growing youth, new possibilities of health are available in all climates. If accompanied by a right diet there may result a considerable increase in the initiative of individuals and perhaps of whole peoples. Anthropologists have maintained that the right diet has had a great deal to do with the development of man and that his capacity to go ahead has come because the right diet made him feel right to do right, and also gave him the ability to start something—some of the things he started not being perhaps worth while, but nevertheless a part of the constant flux and change about us.

The biological engineer's greatest responsibilities come where groups of individuals are handled—in a factory, in a community, or in a nation. Industrial hygiene has taken on new significance and has relationships particularly to chemistry and physics that are yet largely undisclosed. With the constant creation of new substances brought into industry it is inevitable that new problems will arise from the effects of these substances, either immediate or remote, upon living tissue.

Certainly the physician must think in the terms of biology and must know the physiology of the body and all of the cells making it up if he is to guide the human being through his difficulties. While this body of ours is a satisfactory engine in the ordinary normal existing environment, the rapid changes that we are making in that environment may materially change its reactions.

If this picture that I have given is not an exaggerated one, and if there has been this constant change in medical practice from day to day, ought we not to go deliberately at the preparation of the doctor on somewhat different lines than those that have come to us through tradition and an experience which, to say the least, was quite incomplete from the standpoint of modern science? It seems more important than ever before for the young doctor to have a broad basic training and not to specialize too soon in the field of medicine. The doctor's relationships to the social sciences, to economics, to the health of officials, to the operation of armies, and to industry make it important for him to understand the principles of economics, to have a knowledge of history, to know much of psychology, and even to be interested in politics. I can think of only three subjects that *need* to be a part of the early training of the physician, and these are chemistry, physics, and biology. Not too much of any one of these three should be required if by that requirement we interfere with the broader training of which I have spoken. The medical course itself should be undergoing constant change. It needs to recognize the importance of the work in biophysics and biochemistry, to eliminate a lot of the old forms of therapeutics, and to discard as rapidly as possible unessential historical items in such fields as bacteriology, pharmacology, physiology, medicine, and surgery. It should reserve for the hospital years practically everything that

has to do with the specialist, but should concentrate upon a thorough training in physiology, pathology, medicine, surgery, public health, and preventive medicine. We can no longer view our medical knowledge as divided into segments, each one of which can be carefully delineated from the others. We have to think of our factual knowledge as a constantly flowing stream which shows certain trends and which we cannot lock up into individual compartments or keep in different pigeonholes. It seems to me that a special effort should be made to train students on the activities of the central nervous system. This may be an intricate and difficult subject, but it is one that can no longer be handled well except by those who have thorough preparation. The very processes by which we have prolonged life and built up modern society have given us more and more responsibility for the care of those with inadequate or damaged brains, who would have succumbed under the harsher conditions of an earlier period.

I have tried to present the physician as a biologist who is using his biology to help steer and handle the human engine. There is no other creation so significant as that of the human body. The doctor needs to know all of its parts and all of its functions, but, above, all, he needs to understand just what human beings are and their unique and individual responsibility to what we call "life." We are inclined to pay too much attention to what we call "success in life" and to measure its value by achievement and what we call "character," without a realization that unless the reproductive function is wisely used and in accordance with the development of individuals and of their limitations we can have but little success as a race. There is a good deal of talk about "good behavior" and "double standards" and various other things. Their real significance lies in the fact that unless we have a code of sound biological behavior we not only greatly increase human discontent, but can destroy the race. The long period of immaturity of the human animal demands that the family have permanency. We cannot expect to have a hit-and-miss moral code in a realm where children are involved and expect to succeed as animals subject to the rules of biology. Our whole aim should be to make better animals and better people. We can make better animals only if we respond adequately to the laws of biology controlling improvement in stock and in the race. An adequate understanding of human breeding and proper guidance by a biological engineer would seem to make it possible for us to avoid the constantly recurring surgical operations of society which we call "war" with their destruction of the lives of soldiers and with damage for generations extending into the civilian population.

When man decided to get out of the trees, come down on the ground and get around on his hind legs in order to get more food to eat, he made a great decision. It gave him the chance to capture the world. He was able to do this because he had intellectual qualities and a body with considerable capacity for adjustment. In spite of various vestigial remnants, such as the appendix, and some

rather unfortunate relationship of the joints and bones, the human body is capable of carrying on its task over a number of decades with satisfaction. The doctor's business is to insure a healthful span of life, but he can be only a guide. Each man runs his own gullet and decides just what shall pass through it.

The moral and spiritual qualities of man make him significant. Without them he would be just another one of the tribes of living things that have come and gone upon the surface of the earth. We have not given our brains full play in trying to use what we call conscience, or our sense of spiritual and idealistic values or our unusual capacity for coöperation. We, as doctors, know that we have in hand information which, if properly used, would change the whole status of man by giving him comfort and ease. Perhaps that very process might at the present time be a source of damage to him. The things that build character seem to have to come hard and often arise out of trouble and pain. The biological engineer must have constantly in mind the fact that he may be doing some harm by doing too good a job of protection.

At any rate there is no greater value in the universe that we know about than a new baby. What we need to do is to try to see that everything that can make that baby happy and well shall be done, that its nervous system shall grow in keeping with its body, that its environment shall be wholesome, that satisfactory habits will be developed and that, above all, the true and clean processes of normal biology, with their various implications, may be put into play in order to give us a human society that is worthy of permanent existence.

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SOME ASPECTS OF NUTRITION IN SURGICAL PATIENTS*

By I. S. RAVDIN, M. D.
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PART I

WITH the development of antisepsis, and later asepsis, the technical aspects of surgery received renewed impetus and the surgery of the body cavities and their contents became commonplace. During this period, anatomy and pathology were emphasized in the training of the surgeon. It was believed that if the operator had an intimate knowledge of anatomy and a working knowledge of pathology he had all the basic science training that was required. At the beginning of the century the basic medical sciences, as we understand them today, began rapidly to expand so that a more comprehensive picture of normal function became available. Surgeons were slow to accept the results of physiological investigations, so that little attempt was made to apply these to the problems of the surgical patient. Even when attempts were made

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to do this, much that we did lacked critical judgment. On every surgical ward rounds, one heard the statements, "push fluids," "give salt," "maintain glucose balance," and a host of other terms which were used without knowledge of the complexity of the processes involved in the condition which the individual patient presented. Such a program often did as much harm as it did good.

Within the last two decades surgeons have recognized that the intelligent evaluation of many of the problems of pre- and postoperative care demand an intimate knowledge of fundamental physiologic principles. I should like to discuss with you a few nutritional problems of the surgical patient, for we believe that a better understanding of them may lead to a reduction in the morbidity and mortality of certain operative procedures.

GENERAL CONSIDERATIONS

One of the most common conditions which the surgical patient presents is malnutrition. Either as the result of a restriction in the diet because of pain or vomiting; the existence of an accessory foodstuff deficiency; the failure of certain viscera to synthesize the split products of foodstuffs so that they may be deposited in the organism; the loss of excessive amounts of these synthesized substances; or, as is not infrequently the case, because of an inadequate diet imposed upon the patient by one who knows little about the complex problems of nutrition, the patient frequently comes to operation in a state of profound nutritional imbalance. One of the most important of these deficiencies is related to a restriction of the intake of protein, the excessive loss of protein, or the failure of protein synthesis in certain important viscera such as the liver.

Prolonged restriction of protein in the diet causes a reduction in the concentration and the total amount of the plasma protein. The chief function of the plasma protein is to keep fluid in the blood vessels. It does this through the colloid osmotic pressure which it exerts. Starling¹ pointed out that the osmotic pressure of the plasma crystalloids, although large (5,000 to 6,000 millimeters of mercury) as compared with that of the plasma protein (30 millimeters of mercury) is of little importance in keeping fluid in blood vessels because crystalloids pass freely through the walls of these vessels.

It is now more or less generally agreed that as the concentration of the plasma protein is reduced from its normal of approximately 7.0 grams per cent, and the osmotic pressure exerted by the protein is proportionally reduced, fluid begins to leave the blood vessels, resulting, first, in a latent and, finally, when the accumulations in the extravascular reservoirs become great enough, in evident edema.

Latent and manifest edema have become more frequent in surgical patients as the enthusiasm of surgeons and their house officers for the intravenous introduction of large amounts of salt solution increased. Weech and Ling² have shown that the introduction of large amounts of neutral sodium salts will intensify the edema occurring at any given level of the plasma protein and, likewise,

if the sodium ion is restricted it is often difficult to produce edema even though the plasma protein concentration is reduced.

We have frequently obtained evidence in our patients that as the plasma protein concentration is reduced from its normal level, decreasing amounts of fluid and salt are required to cause edema. It should be remembered that evident edema of the subcutaneous tissues is but an external manifestation of a general process. Its occurrence in the postoperative patient is too frequently the result of lack of knowledge of the physiochemical mechanism of the movement of fluids across vascular membranes.

It is of the greatest importance that the clinician look upon the plasma protein and the stores of protein in the body as complementing each other. Except in those conditions in which the loss of plasma protein occurs rapidly, a reduction in plasma protein concentration is nearly always associated with a reduction in the stores of easily mobilizable protein of certain viscera. Regardless of whether one accepts Whipple's³ concept of "labile stores" of protein, the work of Addis, Poo, and Lew,⁴ and Luck,⁵ demonstrates that loss and replenishment of protein stores does take place during the restriction and ingestion of protein in the diet. Addis and his associates,⁴ in a study of the loss of protein from various tissues of the body during a fast, found that the liver loses so much more of its original protein content than any other organ that it "suggests that it may be a depot for stored protein and that this special sort of protein may be used during fasting in much the same manner as glycogen during a fast."

In many of the circumstances presented by surgical patients, restriction in intake of a suitable diet leads simultaneously to a depletion of easily mobilizable protein stores and to a serious reduction in the total amount and concentration of the plasma protein.

NUTRITIONAL EDEMA

Several years ago we began to interest ourselves in the patients who, following posterior gastroenterostomy or partial gastrectomy, gave evidence that the new stoma was not functioning normally. The explanation existing at that time for this malfunction was purely an anatomical one, for surgeons believed that a mechanical defect in the method of anastomosis prevented efficient gastric emptying. This gave rise to the general term "vicious circle." We were convinced that the stomata in our patients were adequate in size when we made them and that from a simple anatomical viewpoint nothing was wrong with the length of the loop, the direction of its placement, or the method of suture. Careful study of several of these patients disclosed nothing beyond occasional mild or moderate superficial edema, as a rule a low level of the plasma chlorid, although at times this was above the normal concentration, and frequently a low level of the plasma protein.

These studies were begun at a time when we believed that the intravenous administration of large amounts of sodium chlorid was the major

item of postoperative therapy. The extension of this type of therapy by surgeons took place without full knowledge by them of the control of fluid and electrolyte balance. Large amounts of saline solutions were often administered without careful blood studies. In the entire clinical surgical literature of this period on intravenous fluid administration to surgical patients, with the exception of papers dealing with increased intracranial pressure and shock, one finds hardly a reference to the forces which govern the movement of fluid into and out of the blood vessels and the intercellular spaces. Surgeons were generally unaware of the Starling hypothesis or ignored it.

Jones, Eaton, and White⁶ were the first to report observations on the frequency with which edema may be present in surgical patients, and their experimental studies added greatly to our knowledge of this subject.

Mecray, Barden, and I⁷ demonstrated that in otherwise normal animals even poorly made stomata functioned moderately well, and became convinced that a simple anatomical basis for "vicious circle" was not sufficient to account for many of these complications. When, as the result of a diet low in protein and repeated plasmaphereses, we reduced the serum protein concentration in dogs, we then obtained evidence of an increase in the time necessary for the stomach to empty a water barium meal. When hypoproteinemic dogs were given sodium chlorid intravenously, the gastric emptying time was still further prolonged.

When these hypoproteinemic animals were sacrificed we found that the gastro-intestinal tract, as well as the subcutaneous tissues, showed evidences of a widespread edema.

Dogs which had been subjected to a subtotal gastrectomy and had fully recovered from the operation were also studied fluoroscopically for their rate of gastric emptying. When these same dogs were made hypoproteinemic the gastric emptying time was greatly prolonged. Even the cecum appearance time, or the time necessary for a bolus of barium to move from the pylorus to the cecum increased, indicating the effect of edema on the small intestine.

The problem of nutritional edema in man—using this term in its broadest sense—is often complicated by a number of other factors. In many of the patients coming to us for gastro-intestinal operations there has existed not only a deficit of the primary foodstuffs prior to operation, but also a deficit of the accessory foodstuffs, the vitamins. The studies of Cowgill⁸ and his associates have demonstrated the close relationship of certain of the vitamin deficiencies to alterations in gastro-intestinal motility.

At the time of admission to the hospital the plasma protein concentration of the patient is often within normal limits because of dehydration, but when attempts are made to overcome the dehydration, prior or subsequent to operation, the plasma protein concentration frequently drops and fluid retention in the extravascular fluid reservoirs begins.

When the edema of trauma is further accentuated by the edema of hypoproteinemia the newly

made stoma of the gastro-enteric anastomosis will not function normally, and a moderate or serious delay in gastric emptying results. We believe that the edema at the site of the operation may so reduce the size of the newly made stoma as to provide a mechanical impediment to gastric emptying. Gastric tone may be normal, gastric peristaltic waves equal to, or greater than their normal depth, but gastric contents remain in the stomach.

The administration of large amounts of salt solution in the postoperative period will intensify and prolong the edema so that the picture which the patient presents mimics in every way a mechanical defect of the anastomosis.

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(To be concluded)

ENDOCRINOLOGY: A CRITICAL APPRAISAL

By EDWARD H. RYNEARSON, M. D.
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PART II*

THE PANCREAS

ANY consideration of the underfunction of the pancreas would involve a discussion of the entire subject of diabetes mellitus, which is obviously impossible in a paper of this length.

Hyperinsulinism, the antithesis of diabetes mellitus, is an extremely rare disease. Unfortunately, the condition of hundreds of patients is diagnosed as hyperinsulinism, simply because they feel a little weak or have other vague symptoms between meals, or because the sugar-tolerance test shows a flat curve. The term "hyperinsulinism" should be reserved for patients who have actual disability with definite, clear-cut symptoms simulating in all respects those of a severe insulin reaction. These symptoms follow a definite pattern and are produced by fasting or physical exertion. The level of blood sugar is consistently low during attacks, and symptoms are speedily relieved by the prompt administration of sugar. If hyperinsulinism actually exists, the patient should have the opportunity of a thorough exploration of the pancreas, for if an adenoma of the islet cells is found and removed the patient is cured. Unfortunately, adenomas are

* Part I of this paper appeared in the June issue of CALIFORNIA AND WESTERN MEDICINE, on page 257.

not always present. In several instances complete necropsy has failed to disclose any evidence of a responsible lesion.

THE ADRENAL GLAND

Adrenal Cortex.

Deficiency of the adrenal cortex, whether from tuberculosis, atrophy or whatever cause, produces the well-known syndrome of Addison's disease. Remarkable advances have been made in the treatment of this disease, the most recent of which is the synthesis by Steiger and Reichstein⁶ of desoxycorticosterone acetate. This synthetic substance is the most effective substance yet discovered to increase the retention of salt and water. Thorn^{7,8} of Johns Hopkins University has had the greatest experience in its use and has had splendid results in the restoration of patients suffering from Addison's disease. Unfortunately, it does not affect the metabolism of sugar, and several workers have reported the deaths of patients with findings suggestive of hypoglycemia. Unfortunately, also, if given in too great dosage or in conjunction with too much salt, it is likely to cause generalized edema. Thorn^{9,10} has implanted pellets of this substance beneath the skin of patients suffering from Addison's disease with encouraging results. These pellets are not available for general distribution. There is evidence to indicate that when this hormone is used the amount of potassium in the patient's diet should not be restricted, and in some instances the addition of potassium has seemed wise.

There have been no recent important additions regarding our knowledge of the syndrome resulting from the overfunction of the adrenal cortex. The clinical picture is that described by Cushing^{11,12} as occurring with basophilic adenoma of the pituitary. Emphasis should be given to the fact that not every hairy, obese woman has Cushing's syndrome, arrhenoblastoma of the ovary or a tumor of the adrenal cortex. There are thousands of hairy women who do not have any localizable lesion of any gland; they can best be described as physiologic variants, and the only treatment is local attention to the hirsutism. A patient with a tumor of the adrenal cortex has, in addition to the hirsutism and obesity, plethora, acne, hypertension, glycosuria, striae, osteoporosis, and changes in the electrolytes of the blood. The surgical removal of the tumor or hyperplastic adrenal tissue relieves this condition.

Adrenal Medulla.

The rare syndrome of hyperadrenalism results from the overproduction of adrenalin from a tumor of the adrenal medulla. The clinical picture of this condition is that of paroxysmal hypertension with marked associated vasomotor symptoms which are relieved by the surgical removal of the tumor. There never has been a description of a syndrome associated with the lack of the adrenal medulla. Whether some patients with spontaneous hypoglycemia have this condition because of a lack of the blood-sugar raising effect of adrenalin is unknown.

THE TESTES

The most important recent advance in our knowledge of testicular function has been the synthesis of testosterone propionate. This synthetic male hormone has proved of value in the treatment of male castrates and of certain patients suffering from hypogonadism. Unfortunately, it is being used too widely for the treatment of vague conditions, ranging from "male climacteric" to asthenia. It is extremely difficult to interpret the results obtained from utilizing this substance in the treatment of conditions of this sort. Reports have been published which indicate that in some cases about the same results follow the injection of sterile oil. It should be emphasized, however, that this hormone is a valuable hormone when properly used, but its unwise administration is likely to lead to its discredit. Evidence is not sufficient to suggest that it plays any rôle in the reduction of the size of the prostate.

THE OVARIES†

Estrogenic hormones are of two main types: the first includes the naturally occurring estrogens; the other is the synthetic estrogen, diethylstilbestrol. The naturally occurring estrogens are those which are important in causing proliferation of the endometrium of the uterus. They are, therefore, of great value in the treatment of certain patients with amenorrhea and of certain patients who have menorrhagia or metrorrhagia or both, associated with insufficient or incomplete proliferation of the endometrium. These estrogens also produce cellular proliferation of the vaginal epithelium which has led to successful employment of the estrogens in the treatment of gonorrheal vaginitis of the young girl and in the treatment of senile changes that occur in the vagina and external genitalia after the menopause. Estrogens are of great value in the treatment of menopausal states. Finally, it should be mentioned that they are essential for complete development of the breasts.

Synthetic estrogen, diethylstilbestrol, bears no chemical similarity to naturally occurring estrogen. It is now being given a clinical trial in several clinics in this country and seems to be most effective when given orally. It is much more potent than the naturally occurring estrogens.

Progesterone is the hormone of the corpus luteum, and its function is primarily that of differentiating or causing a secretory change to develop in an endometrium that previously has been sufficiently proliferated by the action of the estrogens and beyond which the estrogens continue to exert an effect. This hormone is necessary for the proper function of the pregravid endometrium, for the maintenance of the function of the endometrium during early pregnancy, and is probably necessary for the proper function of the maternal portion of the placenta during the latter part of pregnancy. It acts synergistically with estrogen and has some influence on the metabolism of the estrogens. Progesterone is used at present in those cases of

† This subject is taken up in detail by Dr. L. M. Randall in an article to be published in the *Medical Clinics of North America* (Saunders).

atypical bleeding from the uterus in which the endometrium shows an insufficient effect from progesterone and it probably represents substitutional therapy. It is also used in the treatment of threatened abortion.

Space prevents a discussion of the use of pregnant mares' serum and extracts of pregnancy urine. The latter have had their greatest clinical use in the treatment of undescended testes and have produced satisfactory results in well-selected cases. It should be added that many boys with undescended testes will improve spontaneously without any treatment.

THE PITUITARY

The Posterior Lobe.

The syndrome of diabetes insipidus is easily recognized. Emphasis should be given to the fact that not every individual who drinks large quantities of water and who passes large quantities of urine has this disease. If there is doubt as to the existence of this disease, the question can usually be settled by the study of the ability of the kidneys to concentrate urine. No case of true diabetes insipidus in which the urine could be concentrated to a specific gravity of more than 1.010 has been reported. Individuals with nervous polydipsia concentrate urine normally. The treatment of diabetes insipidus is by replacement therapy, either by injecting pitressin hypodermically or by intranasal insufflations of powdered whole posterior pituitary. The latter method, which is much cheaper, is usually quite effective and does not have the unfortunate side effects sometimes experienced when pitressin is administered hypodermically.

There is no recognized syndrome concerned with the overfunction of the posterior lobe of the pituitary.

The Anterior Lobe.

This subject has properly been left to the last because it is a subject about which most is written and about which least is known. Even those workers in laboratories with thousands of animals at their disposal are not in agreement regarding the physiology of this important gland. These workers cannot agree as to whether there is a single specific growth hormone. They cannot agree as to whether there are one or two gonadotropic hormones, or as to the relationship of the pituitary to the metabolism of food. Are there separate hormones for the metabolism of carbohydrate protein, fat, ketones, and so forth, or a single metabolic hormone as described by Collip?¹³ As a matter of fact, for the present at least, we probably should not refer to pituitary hormones, but rather to pituitary effects. A list of pituitary principles of hormones which have been described include the growth principle, the thyrotropic principle, the gonadotropic principle or principles, the adrenocorticotrophic principle, the mammatropic or lactogenic principle, the diabetogenic principle, the ketogenic principle, and the parathyrotrophic principle. Separate principles have been described which affect the metabolism of carbohydrates, proteins, fats, ketones, and water. A specific metabolic principle

has been described. The existence of a hemato-poietic principle has been suggested.

If our friends in the laboratories are having so much difficulty, how can clinicians be expected to evaluate properly therapeutic uses of these unknown substances for undiagnosed conditions? A review of the medical literature leaves doubt as to whether any anterior pituitary hormone produces any effective substitutional effect. The hormone which has had the most extensive clinical trial is the growth hormone, and yet it has never been reported that a pituitary dwarf has been restored to normal height by the use of the substance. At a recent meeting of neurosurgeons from the United States and Canada, this question was asked: "Is there anyone at this meeting who ever has seen any patient with pituitary insufficiency of any type improved by the administration of any pituitary extract yet available?" No one in the audience had ever witnessed any such improvement.

Clinical observations are in a more confused state than the observations of the laboratory scientist. Conditions which are related to a disturbance of the anterior lobe of the pituitary include dwarfism, Fröhlich's syndrome (dystrophia adiposogenitalis), Laurence-Moon-Biedl syndrome (?), Simmonds' disease, hypopituitarism associated with chromophobe adenoma of the anterior lobe of the pituitary, gigantism, acromegaly, and Cushing's syndrome attributable to adenoma of the basophilic cells. There is little evidence to suggest that treatment with any hormone is effective in any of these conditions. Reports have been published indicating an improvement in Simmonds' disease, but all of these cases are open to serious question. Most patients whose condition is diagnosed as Simmonds' disease have in reality anorexia nervosa. Lissner and Escamilla¹⁴ were able to find only sixty-nine verified cases of Simmonds' disease by a complete search of the literature.

COMMENT

This incomplete and informal discussion emphasizes the need for a conservative approach to the better understanding and treatment of these complicated clinical syndromes. Endocrinology is one of the newest and, to me, one of the most fascinating fields of internal medicine. Because of its infancy, there are many evidences of growing pains and some years will pass before, if ever, the study becomes a science.

Mayo Clinic.

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Note: "Suggested Reading" references appear in this issue on page 51.

MALARIA: A CLINICAL SUMMARY*

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MALARIA in California.—An instructive review of malaria in California appeared on January 6, 1940, in the Weekly Bulletin of the California State Department of Public Health. The disease was known in 1840 and increased during the Gold Rush period. From 1849 to 1854, malaria was prevalent in army posts, at one time in northern California affecting 816 per 1,000 men. Its geographic distribution was the same as now. In 1856 a virulent type of disease appeared following the importation of large numbers of Italian laborers for the construction of the first railroad in the state, from Sacramento to Folsom. In 1857-1858 there were authentic reports of wide incidence and serious inroads on the population of Indian tribes. In the eighties, "there were heated arguments between medical men and agriculturalists as to the rôle that irrigation might play in the spread of malaria."

CALIFORNIA STATISTICS

Malaria reporting improved greatly after 1890, the California State Board of Health recording 12,109 cases and 227 deaths from January, 1891, to June, 1896. Highest incidence was consistently in July, August, September, and October. The geographic incidence has never materially changed. The first reported mosquito-control work was undertaken in 1903 near San Rafael, and the following year in San Mateo County. In 1910 Prof. William B. Herms of the University of California conducted the first campaign against malaria-bearing mosquitoes at Penryn in Placer County, followed by a similar enterprise at Placerville in Eldorado County. During the years that followed, volunteer work in mosquito control was carried on in other communities; but it was not until after 1915, when the mosquito abatement act was placed on the statutes, that widespread activities in mosquito control were undertaken.

* From the Division of Preventive Medicine, School of Medicine, University of California.

The decline in incidence of malaria since 1915 has been so striking that too many physicians consider this disease as entirely exotic in California, and of no clinical importance—forgetting that it is deeply established on an endemic basis, and, while smouldering, carries the constant danger of local or even general flare-ups, if precautions are relaxed.

From 1914 to 1920 inclusive, 4,759 cases were reported. In the decade from 1921 to 1930, 1,277 cases were recorded.

The figures for reported incidence in the five years ending with 1939 have been secured from the California State Board of Public Health.* A summary of these figures is as follows:

	Sub- tertian	Simple Tertian	Quartan	Un- known	No History	Total Cases
1935	13	111	7	38	4	173
1936	13	140	1	32	3	189
1937	19	79	8	38	2	171
1938	19	243	4	89	4	358
1939	16	203	5	48	12	284

COMMENT

It is worthy of comment that all types of malaria are still present, that the general distribution is approximately the same as a century ago, and that this endemic area lies chiefly in and contiguous with the central valleys of the San Joaquin and Sacramento rivers. Faust¹ estimates that each reported malarial death represents some 415 cases, and that the reported cases actually represent a much larger morbidity. The California reports are for cases only.

It is evident that the problem of malaria in California has been solved only in part, and that its eradication will require continuance of an intensive campaign. Decreased money and effort can only result in return to an incidence proportioned to the ratio of the present population to that of a century ago. The present incidence, and the definitely known increase of imported cases, make malaria of real importance to the clinician in California. Malarial incidence tends to run in waves having peaks at five- to seven-year intervals. It is easy to confuse regressions in these waves with results of antimalarial campaigns, and to allow relaxation of effort because of such a misinterpretation.

ETIOLOGY

Malaria is caused by infection with one or more of four kinds of plasmodia.

Plasmodium ovale causes both pathologically and clinically a mild and infrequent form of benign tertian malaria which tends to die out by itself. It has been suggested that it is a new parasite in the human host which is not yet well adapted or established. Its prognosis is excellent.

Plasmodium malariae causes quartan malaria, which has an unexplained patchy distribution suggesting that it is dying out as a human parasite. Quartan malaria is the most persistent of all forms, and the most resistant to treatment. It may persist for six to seven years. Relapses are extremely common. The mortality is low, even lower than

* Statistics through the courtesy of Miss Ida M. Stevens, supervising morbidity statistician.

in benign tertian malaria. The temperature chart may give a quicker diagnostic lead than the finding of the usually very scanty plasmodia. Double infection may be seen, but triple infections are rare. Subacute or chronic nephritis is prone to attend quartan malaria.

Plasmodium vivax causes benign tertian malaria. The fever may be irregular or even remittent in the early stages of a first attack. Gradually, however, the characteristic tertian periodicity with intermittence appears, and is the usual fever type in relapses and in secondary attacks. Quotidian fever may be seen during the onset, gradually assuming a tertian cycle, and, later in the course, due to double infection. After some two to three weeks the paroxysms in an attack tend to lessen in severity and then cease. There may be no relapse, but usually after two to ten weeks with little or no fever, a second attack follows, lasting for a few days. Lacking treatment these recurrent attacks may persist for a year or more, generally becoming less severe as immunity increases. Rarely, however, does the patient lack more or less treatment. Even inadequate treatment is valuable, tending to prevent or decrease anemia, splenomegaly, and cachexia. Benign tertian malaria is rarely fatal, but tends to become chronic and so to pave the way for intercurrent infection, and to cause incalculable social and economic loss by weakness, lassitude, and physiologic inefficiency. Increasing immunity may change the usual direct relation between symptoms and number of parasites. Parasites may persist in the absence of fever. Children tend to irregular temperature curves, and chills may be slight or absent. Fever may be missed if it occurs only in the night. Anemia and splenomegaly are important guides. In tertian malaria, the relapse rate is high, being common up to one year, rare after three to four years. Benign tertian malaria is less dangerous, but much more resistant to treatment than subtertian or malignant malaria.

Plasmodium falciparum causes subtertian or malignant malaria. This is the most dangerous and fatal form. The fever is irregular, often low when the symptoms are dangerous, and trivial symptoms may suddenly change to delirium or coma. Rigors are inconstant. Pernicious symptoms, such as coma, vomiting, jaundice, and delirium require instant attention. Malignant tertian should always be considered dangerous. The symptomatology is protean, and may simulate almost any clinical syndrome. This is due to the more intense toxemia, and to the fact that those red cells containing growing forms of *P. falciparum* tend to agglutinate in capillaries and sporulate *in situ*, causing blockage and intense local damage from released toxin, impaired local circulation and possibly from released pigment. As a result, also, growing forms (trophozoites) tend to disappear from the circulating blood, so that only young (ring) forms and sexual forms (gametocytes) are apt to be found on blood examination.

In untreated cases, the temperature tends to fall after a week, with one to four relapses of a week each, separated by one or two afebrile weeks. The

first attack or any relapse may suddenly show pernicious features or may prove fatal, although in general the relapses tend to become less severe, and late relapses (after one year) are uncommon.

DIAGNOSIS

Diagnosis invariably rests on microscopic examination of the blood. In endemic areas the working rule should be to suspect the presence of malaria invariably, even though other diagnoses are definite. Certainly, on the other hand, when quinin or atabrin, in proper dosage for three to five days, does not reduce temperature to continuous normal for at least a few days, then the fever is not malarial. Malaria is peculiarly a children's disease because of their high susceptibility, and especially in small children the symptomatology is so modified that the diagnosis may be missed if no blood examination is made. Congenital infection through the placenta can take place. Chills, chilliness, and sweating may be absent and the frequently low fever may appear only at night and thus be missed. Convulsions are common and may be periodic or very frequent. Splenomegaly follows soon after development of anemia.

The common clinical evidences of malaria are (1) splenomegaly, (2) periodicity of fever or symptoms, (3) history of possible exposure to infection, (4) fever, and (5) a more or less typical blood count. This tends to show leukopenia, and a definite mononuclear increase which, if it reaches 15 per cent, is nearly diagnostic. Henry's flocculation test on the blood serum is of strong presumptive value. Along with syphilis, malaria is noteworthy for its protean clinical picture. It should, therefore, be frequently suspected and rarely diagnosed in the absence of demonstrated plasmodia.

PREVALENCE AND IMPORTANCE

Malaria probably has the highest world incidence and socio-economic effects of any single disease. There is reasonable doubt that its gross incidence has been reduced by the advances of the past thirty-five years. It is nonetheless true that in limited areas, and in special or selected populations, its severity and mortality have been reduced, with no reduction in its incidence. Malaria control is ineffective in general because it is based on methods highly expensive in the departments of sanitary engineering and trained personnel. Reduction in finances means increase in malaria. The disease increased in 1933-1934 in the southern United States. This may be in part in line with reduced public health budgets, and in part associated with the cyclical epidemiology of the disease.

Meleny² states that in 1934 there were approximately 3,900 deaths reported from malaria in the thirteen southern states. In the same time and place, 2,200 deaths from typhoid were reported and 2,000 from diphtheria. The total deaths from these two diseases were little more than from malaria alone. Dauer and Faust³ found that three-fourths of the deaths from malaria were in one-third of the counties in the states concerned. This means a fairly localized problem. Meleney states that,

theoretically, present knowledge of diagnosis and treatment should prevent any deaths at all. The highest death rates were under the age of five and over the age of forty-five. Uncomplicated malaria was more common up to fourteen years of age and complicated malaria after forty-five. The most frequent complications were pneumonia, then nephritis, acute intestinal disturbances, myocarditis, anemia, and cerebral hemorrhage. Most of the fatal cases ran a rapid acute course. He concludes that the attack on the malarial death rate must be by means of early diagnosis and effective treatment. In 1935 it was estimated by the Metropolitan Life Insurance Company⁴ that there were 900,000 cases of malaria in the United States.⁵ Faust⁶ reviewed the figures for 1937, finding in that year a decrease in malarial death rates in all of the states in the area, the average death rate in fourteen states having fallen from 10.2 to 6.9 per 100,000. Faust summarizes as follows: "On the whole, however, the evidence consistently supports the view that the recurrent cyclic curve of deaths, which developed to a peak so suddenly in 1933, has apparently reached its trough, and that, unless unusual circumstances supervene, an average rise in the rate may again be anticipated in 1938 or 1939."

PATHOLOGY

The pathology of malaria is extensive and difficult to summarize. It is characterized by the large dark spleen, which is larger in children and in malarial cachexia, and less in proportion to increased immunity. The spleen is the nursery of plasmodia and the chief recipient of malarial pigment. The liver is enlarged and disturbance of function increases as the acute malarial attack proceeds.⁷ Practically all of the organs are affected. The cerebral and pial capillaries in fatal cases of subtertian are found congested or blocked by schizonts and sporulating forms of plasmodia with punctate hemorrhages in the white matter of the cortex. So-called malaria granulomata and focal degenerations may follow such hemorrhages. Pigment deposit and congestion are found in the marrow and at almost any point in the body.

The histopathology of malaria, in respect of the function and origin of macrophages in defense, has been splendidly studied by Taliaferro and Mulligan.⁸ As summarized by C. A. Bentley,⁹ "the authors consider that general defense reactions are essentially local reactions in strategically placed organs. When malarial parasites are introduced into an immune animal, there is: (a) regional concentration of parasites, and (b) increased phagocytic action." In experimental infection of monkeys with *Plasmodium knowlesi* and *Plasmodium cynomolgi*, "the authors find that phagocytic activity, lymphoid hyperplasia and the concomitant cytogenesis of macrophages are initiated in the spleen and are always most pronounced there; but similar changes, though in a less degree, also occur in the liver and bone marrow as the intensity of malarial stimulation increases."⁸

The features of malarial blood are well described in textbooks. It has been estimated that one para-

site for each hundred thousand red cells is necessary to produce symptoms. The secondary anemia is partly toxic and partly due to rupture of red cells by maturing plasmodia. Malarial pigment in macrophages, leukocytes and endothelial cells is pathognomonic. Pigment from destroyed red cells causes hemoglobinuria, which results in increased production of bile. If this bile outflow is excessive, it may cause vomiting and diarrhea.

"Malarial cachexia is a chronic condition following one or repeated malarial attacks, with persistent secondary anemia, sallow or even icteric skin, edema, emaciation, often enlarged liver, and always splenomegaly. The patient usually has irregular recurring fever. Emaciation, dry skin, asthenia, psychasthenia, and neurasthenia are the rule. Functional disorders are common, and these may be periodic, replacing or accompanying periodic fever. Plasmodia may go through their life cycles with no fever or acute symptomatic indications. . . . The condition is difficult of cure and the plasmodia are difficult to eradicate. . . . As one would expect, tuberculosis and dysenteries easily gain headway. Little exact information is available about the precise influence of complete eradication of plasmodia on malarial cachexia." Traumatic rupture easily occurs.

IMMUNITY

For a long time the conviction has been increasing that malaria produces some kind of immunity which is probably different from true bacterial antibody production, but which is nonetheless protective to a degree. Natives of endemic districts suffer much less from clinical effects of malaria than do newcomers.⁵ First infections in children or adults are apt to be severe. After some fifteen years of repeated attacks, maximal immunity seems to be reached. But there is often a peculiar lack of immunity to other species of malarial plasmodia, and the immunity in general seems to depend to an unknown degree on the continued presence of plasmodia in the patient (see especially Coggeshall¹⁰). Latency or subclinical infection seems necessary to maintain or increase immunity. Wilson & Wilson¹¹ have shown that the immune status is dependent on the frequency of infection, and not on race. They find the most accurate index of endemicity to be the frequency of infections in the nonimmune, that is, the rate in early infancy. In highly endemic regions the infection is acquired in infancy and early childhood. The parasite rate and spleen rate tend to increase to a maximum between three and ten years of age, and then gradually decrease to adolescence when the maximal immunity is reached. In such regions the adults are fairly immune, but with a moderate percentage of enlarged spleens and a scattering of parasites present in the blood. So far, the nature of malarial immunity is not known. True antibodies have not been demonstrated.

Continuation of studies on immunity, such as those of Taliaferro, Coggeshall^{8,10} and others, offers today the most hopeful field for advance in the control of malaria.

TREATMENT

A very concise statement of the principles of treatment where mass treatment is not required and where heavy endemicity is not present, may be given as follows:

1. *Quinin* has its chief action against the growing forms (trophozoites) of malarial parasites. In benign (simple tertian and quartan) infections, one gram (16 grains) of a quinin salt daily, given in three divided doses for five to seven days, has a definite action on clinical symptoms and causes the disappearance of trophozoites until the first relapse occurs. In malignant (subtertian) infections the dose should be increased to 1.3 grams (20 grains), and in some localities to 2.0 grams (30 grains) daily.

Quinin has only a slight action on the sexual forms (gametocytes) of subtertian malaria, although it is a fair gametocide in simple tertian and quartan infections. It has no action on the infective or invading forms (sporozoites) of any malarial parasites.

2. *Atabrin* is somewhat quicker in effect on simple tertian than is quinin, has the same action on quartan, and is, in general, more effective against subtertian or malignant parasites. Its action against sexual forms is the same as that of quinin. It does not affect sporozoites. It frequently causes a yellow pigmentation of the skin which lasts some two or three weeks. The effects on the patient of long-continued use are not well known.

3. *Plasmoquine* acts mildly against the plasmodia of simple tertian and quartan malaria, and almost not at all against subtertian or malignant parasites. It is the best known drug in its effectiveness on the gametocytes (sexual forms) of all malarial parasites, especially those of malignant, or subtertian malaria. Plasmoquine is highly toxic, and a safe dosage should never be exceeded. It should only be used where the patient is under adequate medical observation, and where protection of local anopheles carriers is of importance. When used the dosage should never exceed one grain (0.065 grams) each day for five to seven days.

4. No other drugs have a satisfactory specific action in malaria. Suprarenin, given by the Ascoli method of gradually increasing doses intravenously, at times is most effective in resistant chronic malaria, especially when combined with quinin. Arsenic is an excellent addition to inorganic iron for the treatment of malarial anemia. Carbarsone in the dosage of one grain (0.065 grams) thrice daily is easily combined in capsule with exsiccated ferrous sulphate or iron and ammonium citrate. Neosalvarsan is partially effective against simple tertian trophozoites. Sulfanilamide compounds, while effective in certain forms of monkey malaria, have not justified their use in human malaria. So-called provocative methods, especially for diagnosis, are largely useless and always ill-advised.

5. *Drug prevention* of malaria is impossible, as no substance is known which will destroy sporozoites or prevent their inoculation into the body under suitable carrier conditions. From five to ten grains daily of a quinin salt will usually prevent develop-

ment of clinical symptoms, at the price of frequent cinchonism and decreased effectiveness when larger doses are used for cure. Atabrin can be given, one and one-half grains (0.10 grams) twice daily twice in each week, but should not be continued unduly long until more is known of effects on the human being of long-continued administration. Prevention of mosquito bites is still of primary importance in prevention of malaria. This is facilitated by deterrent applications, proper clothing, and proper use of bed nets.

6. *A practical average routine* in benign malaria is to give 16 grains (1.0 gram) in three divided doses daily for five days in each week for six weeks. The first and fourth courses may well be substituted by one and one-half grains (0.1 gram) of atabrin thrice daily for five days, remembering to warn the patient that a yellow pigmentation of the skin is a frequent and apparently harmless sequel. In malignant (subtertian) malaria, the quinin dosage should be raised to 20 grains (1.3 grams) daily. The dosage noted for atabrin should never be exceeded.

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CHILD FEEDING: A PROGRAM-OUTLINE*

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THE well-balanced varied menu of the adult assures the normal individual of the necessary food constituents. The limited diet of the infant and small child necessitates a more scientific approach if it is to meet the needs of these early years. This paper outlines a program of child feed-

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ing which represents our interpretation of available scientific data and clinical experience in terms of practical food units. The psychological approach, as well as the physiological needs, are considered.

PHYSICIAN'S INTERPRETATION OF INFANT'S NEEDS

There are no scientific criteria of the nutritional condition and food needs of the infant. We have only the physician's clinical interpretation of the condition of the child based on weight, muscle tone, general hygiene, sleep habits, behavior, etc.; and even this interpretation is influenced by individual opinion. We know that the child's most elemental need is that of food and that this food must be adapted to his ability to utilize it; it must be easy to digest; it must contain a high level of protein, mineral salts, and vitamins in order to meet his growth and energy requirements; and it must assume gradually the form and variation of the food of the adult.

RECENT STANDARDS

By means of many studies on the apparently normal child, Sherman, Bogert and Porter, Rose, and other workers in this field, have developed standards to meet these needs. It is a well-established fact that the child consumes more energy, in proportion to its size, than does the adult. These authorities have found that a high caloric intake is necessary to meet the high energy need, that during the first year of life 50 calories per pound are required to feed this energy, as compared with 30 calories per pound during adolescence. Of this high caloric intake, at least 15 per cent must be in the form of protein and at least two-thirds of this protein should be in the form of animal protein, the amino-acid content of which is more efficient for growth. A carbohydrate-protein-fat balance of 50-15-35 has been found to be the most efficient in securing the optimum utilization and burning of the food.

The standards for the smaller units of the diet are less well established. Bogert and Porter's¹ recommendations, however, represent a practical average. Those authors suggest at least 1 gram of calcium and 1 gram of potassium daily, and from .6 to .75 milligrams of iron per 100 calories of food taken. Of the vitamins, Bogert considers as necessary 250 Sherman units of vitamin A and 30 Sherman units of vitamin B₁ per 100 calories; and at least 20 Sherman units of vitamin C and 135 U. S. P. units of vitamin D, daily; necessary amounts of vitamins B₂ and E and the more recently discovered vitamins are still undetermined.

The interpretation of these standards in terms of the daily diet has produced a vast array of food plans for the child. A comparison of certain points of these plans, and an attempted evaluation of their respective merits, have convinced us that our program as presented here fulfills the child's food requirements in accordance with our present knowledge.

SUBSTITUTES FOR BREAST MILK

We have no perfect substitute for breast milk. No artificial formula can carry the protection which

is afforded by the immunizing properties of breast milk. Cow's milk, which is our most natural substitute, however, can be sufficiently modified in formula to make it compare favorably with breast milk in all other respects. Its constipating properties can be changed and, in modified form, a curd which more nearly resembles that of breast milk may be obtained. Unsweetened evaporated milk has been growing in favor, both because it supplies the desired small curd and because of the convenience of its use, especially in traveling. It has been shown, however, that cow's milk, and especially milk formulae, are markedly deficient in vitamin C. Therefore, orange juice is given early, even though clinical manifestations of vitamin C deficiency are seldom seen before six months of age. Merritt,² of the New York Babies' Hospital, suggests that it be started before the end of the first month; Bridges,³ of Columbia, suggests that it be started during the second or third month. As a source of vitamin C, citrus fruits have an advantage over the synthetic product when taken orally, since recent work⁴ appears to show that the natural sources of the vitamin undergo less bacterial destruction in the intestinal tract than does the synthetic product, and, therefore, offer greater protection.

SUPPLEMENTS TO MILK

It soon becomes evident that milk alone, which is, after all, quite a dilute food, cannot satisfy the child's increasing caloric needs. We, therefore, seek a more concentrated form of fuel which has more or less the same assimilable properties, and we find it in finely milled cereal. Here again opinions vary regarding the age at which the new food should be started; its addition is recommended at from three to six months of age. All feel, however, that the weight gain of the child constitutes the best criterion for this point.

The constituent of milk which next requires supplementing is iron. Egg yolk is a simple food high in iron which would seem to fill this requirement, but its addition at this age is questioned by some workers because of its cholesterol and lipid content. No deleterious effects from these constituents have yet been shown, however. The addition of animal protein follows the addition of egg yolk quite naturally. Bogert and Porter feel that the child should have egg yolk at from seven to nine months of age, but they withhold all meat, except bacon, until the child is two or three years old. Merritt, on the other hand, suggests the addition of egg yolk at four months and of beef at six months of age.

OTHER FACTORS

With these additions the diet theoretically fulfills all the requirements of the growing body. We now face the problem of meeting the changing needs of the growing child from the standpoint of the mechanics of digestion. By this we mean the addition of sufficient bulk to assure regular and thorough evacuation, with avoidance of foods which would irritate or overtax the still delicate digestive system. While the child is still unable to masticate the coarser foods, this need is met quite satisfac-

CHART 1.—*Diet Schedule*
Two to Four Years

Name Age Date

Breakfast:

- tablespoonfuls fruit, of those allowed.
- cupful cereal, with warm milk and a little sugar.
- soft-cooked egg; or two strips bacon.
- slice dry toast—buttered.
- cupful warm milk at end of meal.

Dinner:

- tablespoonfuls meat or fish as allowed.
- tablespoonfuls mealy potato, with butter.
- tablespoonfuls other well cooked vegetables.
- tablespoonfuls raw vegetable.
- slice dry bread or toast—buttered.
- tablespoonfuls any dessert allowed.
- cupful warm milk at end of meal.

Afternoon:

- cupful fruit juice, diluted with a little water.

Supper:

- cupful milk soup, or meat soup without fat; or
..... tablespoonfuls mashed cottage cheese.
- tablespoonfuls well cooked vegetables.
- slice dry toast—buttered.
- tablespoonful cooked fruit for dessert.
- cupful warm milk at end of meal.

At least four glassfuls of water should be offered daily—between meals rather than at mealtime.

The child should be taught to eat slowly and to drink slowly.

Additions to the present diet should be made gradually, so that the child may become accustomed to one new food before another is given.

The meals should be attractive, pleasant, and punctual.

torily by the use of fruit and vegetable purées. These are added by various workers at from four to nine months of age. Mashed or chopped, followed by whole cooked fruits and vegetables, they make natural stepping-stones to raw fruits and vegetables to which the child is accommodated by gradually increasing dental development. The time for addition of raw fruits and vegetables varies widely—from eighteen months to five years. A similar shift is made from the finely milled to whole-grain cooked cereals during the second year of life, and to uncooked whole-grain cereals in the late preschool years. The addition of these foods serves a double purpose in that they also introduce the child gradually to the foods of the adult world.

With this increase in fruit, vegetables, and cereal, we develop an imbalance in our carbohydrate-protein-fat ratio which requires the addition of a high protein, low carbohydrate food. Egg white supplies this demand as do, later, cottage cheese and lean meat.

The food plans which have been outlined show a general uniformity of opinion regarding the addition of various foods to the diet, but differences of opinion as to the ages at which these foods should be added. From our own clinical experience, as well as from the reported work and experience of others, we have evolved the following general program for child feeding.

FEEDING PROGRAM EVOLVED BY THE AUTHORS

Breast milk is, of course, the most satisfactory infant food. However, since breast milk is not always available, we must be prepared to supply a substitute, even during the first month. At this Clinic unsweetened evaporated milk and Grade A pasteurized milk are considered the best forms of milk for formula purposes. A standard evaporated milk formula for the month-old child contains nine

ounces of unsweetened evaporated milk, fifteen ounces of water, and one or two tablespoonfuls of karo. Since the only actual deficiency, according to our optional standards, is that of vitamin C, strained orange juice is added, beginning with one teaspoonful. If this amount is well tolerated it is gradually increased to one ounce, which furnishes the desired amount of vitamin C for this age. By the time the child is eight months old he should be receiving two ounces of orange juice daily. The amounts of vitamins B₁ and B₂ are also augmented by this addition. Since we find that most babies handle this food well, we feel that its addition is justifiable and desirable. We thus approach more nearly the suggested optimum standards. By similar deduction we have found that it is wise to add cereal at the fourth month, vegetable purées at about the fifth month and fruit purées at about the sixth month. Very ripe raw banana is also tolerated well by most of these babies.

At about the sixth month the maximum drop in the hemoglobin concentration of the blood occurs. This fact has been borne out at our Clinic by repeated hemoglobin determinations. Furthermore, an analysis of the food intake at this age shows that the iron content of the diet has not increased in proportion to the total intake of food. We feel that the advantages of egg yolk as a source of iron for infants outweigh its possible but so far unproved disadvantages. Therefore, egg yolk every other day is now added to the diet. We have been following such a plan for the last ten years with gratifying results. At eight or nine months of age the iron content is further augmented by the addition of scraped beef on alternate days. Meat is added in preference to increasing the egg yolk to a daily portion in order to accustom the child to meat food as early as possible, since at a little later age he accepts new foods less readily.

At eight or nine month of age the average child is being offered ten ounces of unsweetened evaporated milk or more in a formula daily, one egg yolk every other day, one tablespoonful of scraped beef on alternate days, one-half cupful of cereal, one ounce of toast, four tablespoonfuls of vegetable purée, two ounces of strained orange juice, and one tablespoonful of fruit purée daily.

This dietary now approximates closely the standard requirements for the eight- or nine months old child. The iron intake, however, is still 17 per cent below that estimated as the amount necessary for optimum benefit, and the total amount of carbohydrate falls about 25 per cent short of our accepted standard. These deficiencies are easily remedied by increasing the cereal intake and by introducing simple desserts which contain small amounts of egg and sugar.

At one year of age bacon is introduced as the first salted food, and Grade A pasteurized milk is substituted for the milk formula. Further variation of the milk intake may be obtained by the use of milk soups. Mashed and chopped vegetables are started at fifteen months of age and are replaced by whole cooked fruits and vegetables at eighteen months of age. At two years of age the first raw

fruits and vegetables—aside from banana, which is usually given earlier—are introduced.

THE CHILD'S DIET SUMMARIZED

These gradual changes in and additions to the growing child's dietary, which form the basis of our practice, may be summarized as follows: milk (the form to be decided by the physician) is given throughout childhood—about one quart daily; orange juice is added at from one to two months of age; cereals, finely milled, at from three to four months; vegetable purées at five months; fruit purées at six months; egg yolk at six or seven months, and whole egg at about one year; scraped beef at eight or nine months, and other meats during the second year; simple milk and egg desserts at eight or nine months; raw fruits and vegetables at two years; fish and cheese at from two to three years; and whole-grained dry cereals at the end of the second year.

INDIVIDUALIZATION IS IMPORTANT

This schedule represents our interpretation of the growing child's nutritional needs in terms of food. However, individualization must of necessity play an important part if we are to meet the needs of all children. We must keep in mind the fact that our aim is not to stuff the child with certain foods, but to try to supply foods which will meet his particular requirements. The amounts of the various constituents, which the child accepts, may vary from day to day. The important thing is that this optimum amount be offered regularly in one form or another; for instance, if the child persistently refuses egg yolk as such over a period of time, then it should be offered in the form of simple puddings or drinks. We wish to satisfy not only the child's optimum needs, but his passing appetite as well. Dr. Clara Davis of Chicago has shown us rather clearly that the child's appetite serves as the best judge of what he needs, especially that of the small child who has not acquired the bad habits of adults.

A second problem evolves from the problem of individualization, and that is whether or not the child's refusal of food is based on physiological or psychological reasons. Persistent refusal of food has been suggested as a possible indication of allergy; this fact, however, has not been confirmed by clinical evidence. We are finding that the children who are offered their food punctually, in a pleasant and quiet manner, present few eating problems. On the other hand, the child who is constantly nagged by the mother to eat what she feels is the correct thing for him to have soon develops unpleasant feeding habits and becomes a behavior problem. As Dr. C. A. Aldrich has told us many times, the child who is forced to eat is the child who will not eat unless he is forced.

Another disciplinary problem may arise as a result of offering finely divided foods over too long a period. If the child becomes too accustomed to this easy manner of eating, he may refuse to make the effort to chew the coarser foods, even though he is quite able to do so. The transition to coarser

CHART 2.—Foods Allowed

Meats:

Chicken, lamb, beef, tender veal: broiled or roasted; liver and bacon: broiled; all meats prepared and served without gravies. Fresh white fish: baked, boiled, or broiled, and served with butter only.

Eggs:

Scrambled with milk (over hot water), poached, baked, or coddled.

Milk Products:

Whole pasteurized cow's milk: plain or lightly flavored with cocoa. Butter (not butter substitute) may be used in moderate amounts. Cottage cheese: mashed with a fork, and served without added salt or cream.

Cereals:

Wheat hearts, farina, oatmeal, cornmeal or white rice: well cooked and served with milk. Ready-to-serve cereals, not combined with bran, may be served occasionally.

Breads:

Light whole wheat, graham, or white breads; toasted as a rule. Graham and arrowroot crackers may be served occasionally for variety.

Soups:

Milk soups: made with three-quarters whole milk, and one-quarter allowed vegetable. Meat soups: meat broths with fat removed may be offered for variety. Serve soups only at light meal.

Vegetables:

Cooked: summer or winter squashes, string beans, asparagus tips, carrots, young beets, small green peas, fresh baby lima beans, chopped celery, white or yellow turnips, spinach or chard, or tomatoes (without soda), or puréed corn: all cooked in lightly salted water, or canned. White potato: baked until mealy; or boiled in skin, peeled, and mashed. Raw: finely chopped cabbage, grated carrot, shredded lettuce, or peeled meaty tomato.

Fruits:

Cooked: pears, peaches, apricots, apples, prunes, crushed pineapple, or occasional nectarines; well cooked, or baked and served without skin, or canned in light syrup. Raw: sectioned grapefruit or orange, very ripe banana, or occasional apple. Juices: pineapple, orange, tomato, or grapefruit.

Desserts:

Milk puddings: baked rice pudding without raisins, custards, junket (made with tablet), cornstarch puddings, or tapioca cream: all cooked and served with small amounts of sugar; vanilla ice cream. Fruit puddings: apple, peach, or apricot tapioca puddings; fruit Jello. Other desserts: plain or whipped Jello. occasional small piece sponge or angel cake without frosting.

Only the foods listed above are to be used.

foods, then, marks an unpleasant experience for both mother and child. Similarly, the serving of several foods in one mixture encourages the child to prefer them in that way and to dislike them when served separately.

We find that the three-meals-a-day plan is acceptable even for the smaller children. At this Clinic all children are on this schedule, with fruit juice between meals, by the time they are one year old, and some even at six months of age. This is helpful to the mother in cases in which there are several children in the family and, if he is served with other members of the family, is also helpful to the child, for he will unconsciously acquire food habits from observation of others. The mother is thus relieved of many a teaching problem. Furthermore, small food dislikes are overcome since the child will wish to try something which is apparently being enjoyed by someone else. There is a corollary to this statement in that the child will imitate others in dislikes as well as likes, and in poor as well as good food habits; therefore, it behooves the older members of the family to "mind their manners."

The psychology of child feeding covers a broad field. However, its tenets cannot be ignored in planning a food program for children if the physiological needs of the individual child are to be fulfilled.

DIET CARDS

At this Clinic, in order to make this program a working tool for the mother, diets for the different ages have been printed on stiff cardboard with a punched-out hole in the upper center so that the card may be hung in the kitchen, where it is always available for ready reference. On one side of the card (Chart 1) is a list of foods which are allowed, and on the other an outline menu with spaces for filling in the amounts of each food in the individual case (Chart 2). Six different schedules carry the child from eight months of age to the age at which he follows the routine of the normal adult. The first schedule outlines the diet from 8 months to 12 months of age; the second from 12 to 15 months; the third from 15 to 18 months; the fourth from 18 months to 2 years; the fifth from 2 to 4 years; and the sixth for older children. These cards are the outgrowth of many suggestions and requests for condensed workable types of diet schedules on the part of the mothers, and the desire for a time-saving device which would enable her to spend her time in personal interviews with the mother, on the part of the dietitian. By talking to the mother personally, the dietitian is able to explain the diet in detail and to give instructions regarding the preparation of the food. Food idiosyncrasies, likes and dislikes of the child, may be discussed and substitutions made in accordance therewith. As a result the mother has a much clearer understanding of the reasons for a definite schedule and the manner in which it should be carried out. Furthermore, the personal interview gives the dietitian the opportunity to individualize the diet to the needs of the particular child.

SUMMARY

A practical program for child feeding as it has evolved from scientific data, and the personal experience of ourselves and others, is presented. The importance of the psychological approach to the problem is also stressed, as it is felt that this is an indispensable part of any program of child feeding. Finally, the specific, individualized application of this program, as it is carried out at this Clinic, is described.

As our knowledge of food chemistry and values of the nutritional needs of the young child increases, food plans of increasing merit and individual applicability for this age group will be evolved. These programs lay the foundation for the health and development of later life. Their importance, therefore, in the building of a better race cannot be overemphasized.

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IODID OF POTASH: ITS INTERESTING HISTORY

By DOUGLASS W. MONTGOMERY, M.D.
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THE last years of the eighteenth and the beginning of the nineteenth centuries were remarkably active politically. Nothing stirs the human spirit like war and politics, and those were also the years of the French Revolution, the Napoleonic wars, and the founding of the American Republic.

Scientifically there was an equal activity. For example, Lavoisier had cleared up the mystery of breathing; but the politicians do not seem to have kept up with the scientific bent of the times, for, on beheading him, they remarked cynically that the Republic had no great need for chemists.

EARLY OBSERVATIONS

Laennec and Dupuytren were among the many who brought light into the darkness of clinical medicine and surgery, and at the same time, in the same place—the St. Louis Hospital—Lugol was trying out on the scrofulous diseases a metal which Bernard Courtois had recently discovered while lixiviating kelp, and to which Guy Lussac, another chemist, gave the name "iodin" (the "violet one," from the Greek), on account of its color.¹

How Courtois came to work on seaweed, which had always been regarded as utterly worthless stuff, and how he came to pay any attention to the minute quantity of iodine he found, is astonishing.² He undoubtedly was a born chemist, and those imbued with this enthusiasm will investigate anything, no matter how stinking or repulsive it may be. Furthermore, the French have a natural aptitude for chemistry, as shown by their cleverness as cooks.

When it was ascertained that some springs contained iodine, the element experienced its first therapeutic vogue, as it afforded an explanation of their curative value. Up to that time this was attributed to something unknown and spiritual, a *quid divinum*. Alibert, in his work on mineral springs, proposed a classification apart for those containing iodine.³

In 1834, Wallace of Dublin began to prescribe iodine of potash for syphilis, and coincidentally the technique for diagnosing the papular and late gummatous lesions was perfected, and it became a great therapeutic favorite in spite of its occasional disagreeable, or even grave, results. Its use spread far beyond this, its most spectacular field, and in my student days became so general that it was often said that if you were in doubt what to prescribe give iodine of potash.

RICORD'S WIT

The following anecdote also gives some idea of the enthusiasm for this drug. Philippe Ricord was

the most renowned syphilologist of his day, renowned for his wit as well as for his scientific ability. One evening at the opera he was loudly applauding an actress when a friend remarked: "You seem to enjoy her singing." "It is not her voice," he exclaimed, "it is iodid of potash I am applauding."⁴

Judge Niles Searls once told me a story which illustrates how universal the use of this drug had become. It seems there was a druggist in Nevada City who, if a miner came in asking for syrup of sarsaparilla, the then popular blood purifier, he would tell him that it was excellent, but that if he would allow him to add a little something to it he would find it much more efficient. That "little something" was iodid of potash, and frequently, as miners were not famous for sexual morality, he would make a hit and increase his reputation.

ACTION OF IODID OF POTASH

The action of iodid of potash on the lesions for which it is adapted is indeed astounding, but still more astounding was the fact that it did not cure the disease. The human being always tries to explain a phenomenon, and if he cannot find a plausible explanation he invents a word to hide or to gloss over his ignorance. So the remarkable fact that it cleared up, but did not cure led to much word coining. Among the laity iodid of potash was called a "blood purifier." This simple term was, however, far from meeting the requirements of the medical profession, and in my young days "alterative" was the favorite. For those who required a still more obscure word, signifying little or nothing, "deobstruent" was available.

From this lavish employment of iodid of potash the profession has gradually receded. One time, in reading an article by Jadassohn, I noted the author's remark that he found he was prescribing it less and less; and I then realized that this was my own experience.

IODISM

Iodism is a term given to the disagreeable by-effects of the drug. Its lighter manifestations are common enough—a persistent bad taste, running at the nose, lachrymation, and iodic acne. It may affect the respiratory and digestive tracts more severely, causing iodic grippe and even death.

Strangely enough, it may incite tuberculous tumors of most repulsive aspect, resembling those of mycosis fungoides or granuloma coccidioides, or even syphilis; and through these mistakes patients have been dosed to death with the very drug that was causing their trouble.

I shall never forget one of these unfortunate cases that I saw with Theodore P. Rethers and William A. Martin.

REPORT OF CASE

A woman, fifty-six years of age, a patient of Doctor Rethers, was taking moderate doses of iodid of potash for a rheumatic affection entailing difficulty of walking and severe pain across the lumbar region. Soon she acquired an inflammation of the right eye and of its upper lid, and was sent to St. Mary's Hospital. Two days later two small papules appeared below the nostrils, and another below the



Fig. 1.—Photograph showing the lesions on the tongue tip, the exuberant growths on the nose, and the huge erosion on the right upper eyelid.

left ear; and a day or two after this, papules arose in the hollow of the right knee. Soon the ocular condition became so serious that Doctor Martin was called.

I first saw the patient on July 31, 1909, and by August 8 the iodic nature of the trouble became quite evident, when large iodic tuberosities with deep erosions appeared on the nose and on the cutaneous surface of the right eyelid. The administration of the drug was then stopped.

One of the most interesting and unusual lesions was a large blister of the tip of the tongue. It projected out as a bluish cone with a base spreading out and filled with pus. This blister shortly broke and exposed a large tubercle the size of the tip of the index finger. This projected boldly out from its base and had a rough cracked top. On palpation it felt of the same consistency as the normal tongue. A thick dark brown coating of the tongue was continuous over it.

Doctor Martin gave me the following description of the ocular conditions. On the outer side of the globe of the right eye there was an elevation of the conjunctiva, pale in the center and congested at the margin. It was solid in consistency. In a few days this had extended to the limbus and had encroached slightly on the cornea. Rapidly other nodules developed at the limbus, until the cornea was encircled, some of them coalescing. These nodules had a malignant appearance, simulating early sarcoma or cancer. There was no tendency to ulcerate or break down.

On the left eye a process similar to that of the right began the next day. The first nodule appeared like a small phlyctenula on the nasal limbus. The process in the left eye then duplicated that in the right, but on the right it was more difficult to observe because of an erosion with accompanying edema that extended across the cutaneous surface of the upper lid. On August 8, as previously mentioned, the iodid was stopped, and in a week the ocular lesions cleared, except for a slight conjunctivitis.

Coincidentally the cutaneous lesions also receded, as they usually do.

COMMENT

The lesions of the limbi of the eyes, as shown in this case, are very rare. I have never seen them before or since, nor have I run across their like in

literature. It is thought that these very active lesions are due to free iodine circulating in the blood. It is surmised that some individuals have this power of isolating the metal.

IODINE AND GOITER

In 1852, A. Chatin demonstrated that goiter was common where the iodine content of the drinking water was low. This aroused a deal of opposition and was finally discredited. Virchow, for instance, said that it was incomprehensible that the absence of a substance could cause such a positive malady as goiter. Baumann of Freiburg in 1895 discovered that iodine in a firm organic combination, thyroxine, is a normal constituent of the mammalian thyroid and, coincidentally, facts accumulated showing the good effects of adding iodine to water poor in this element, justifying entirely Chatin's views published forty years before.⁵

IODINE AS A CAUSE OF BASEDOW'S DISEASE

The normal human thyroid weighs between three and four hundred grains—from half to three-quarters of an ounce—and as an average contains from one-sixth to one-quarter grains of iodine.⁶

That a grave malady of the thyroid, such as Basedow's disease, should arise from giving an ordinary dose of a metal which is a normal constituent of that very organ is most strange. It appears that this accident is most apt to occur in adenomatous enlargement of the gland. Kocher warned against giving iodine under such circumstances. It may, however, occur when there is no manifest trouble present, as happened to a laryngologist whom I met one evening when dining at the home of Dr. George W. Merritt. He drew my attention to his tremulous hands. He had taken iodine of potash for a small opacity of the vitreous which cleared up, but left him with a much graver condition—with tremulousness and tachycardia.

A surgeon who had made a well-deserved reputation in a town near San Francisco had a similar experience in prescribing iodine to one of his patients. Ever after, when this remedy was indicated, he sent the patient to San Francisco. He did not wish any more such adverse advertisers marching around in his home town.

MODE OF ADMINISTERING IODINE OF POTASH

Nature gives iodine in very small doses; for, although universally present, it is so in very small quantities, the most of it in the sea, into which it is washed from the land.

The normal daily requirements seem to be 1/1600 to 1/1200 of a grain. If given as iodized salt 1/12 to 1/6 of a grain may be added to about two pounds of salt. Cod-liver oil is one of nature's ways of giving the metal, and it contains 1/6 of a grain to a quart, *i. e.*, 1/384 grains to a tablespoonful.⁷

Lugol, who first employed the metal as a medicine, seems to have given it highly diluted and in very small doses to his scrofulous patients. He dissolved half or two-thirds of a grain in a pint of water, to which he might add a few grains of sodium chloride. Of this solution he gave enough

to constitute, at first, half a grain of the iodine, and never more than one grain.⁸

Sutton speaks of a mode of administration which he thinks was first proposed by Sanger Brown. Dissolve an ounce of the salt in a gallon of water and keep it in quart milk bottles in the refrigerator. Take a tumblerful of this at regular intervals.⁹

Before the introduction of modern methods of really curing syphilis with arsenicals and bismuth, with a follow-up of Wassermann tests, the ever-recurring late lesions were treated with iodine of potash, and one got from a daily dose of from fifty to thirty grains just as much effect as from heavier ones.

It is astonishing, however, what large doses may be given, not alone with impunity, but with benefit. Dr. Herbert Moffitt told me of a sea captain with an aneurysm who took three hundred grains a day for ten years. Here it appears to act on the viscosity of the blood, enabling it to glide through the vessels more easily.

SUMMARY OF THE THERAPEUTIC EFFECTS OF IODINE

Iodine is a normal constituent of the thyroid gland, and its absence causes a disease—goiter—quite unlike a deficiency disease. In some people, however, it may incite a grave nervous disorder showing itself as tachycardia, likewise connected with the thyroid, and tremulousness and emaciation. In others, who are said to be idiosyncratic to it, it causes an immense activity in certain tissues, such as the sebaceous glands and mucous membranes, yet it does not increase metabolism. It causes resolution of certain low formed, inflammatory connective tissue growths, especially of syphilis, and to a lesser degree of tuberculosis; yet it cures neither disease.

It can cause all its ill-effects when given in very small doses, yet some can take it for long periods of time without any ill-effects whatever. In fact, it is a remedy full of contradictions and unexpected results, and yet a most useful one when intelligently employed, and is indeed worthy to be placed among the *pauca sed selecta et probata remedia*—the few but select and well-approved remedies.

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THE PRESENT STATUS OF IMMUNIZATION AGAINST PERTUSSIS*

By JOHN J. MILLER, JR., M.D.
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I HAVE been asked to consider the present status of immunization against whooping cough. I have attempted to review this controversial subject and will present to you the evidence available, both pro and con.

THREE TYPES OF VACCINES OR ANTIGENS

There have been three types of vaccines or antigens used with intent to immunize. The first was a suspension of heat-killed or phenol-killed Bordet-Gengou bacilli (*B. pertussis* or *H. pertussis*) made from some of the original strains of Bordet and Gengou. These original strains were used for ten and twenty years. Some are still being used. They have been carried on various media. At first some encouraging reports in regard to the value of this vaccine appeared. Later reports became less favorable. No really thorough field study with these old laboratory strains ever pointed to any efficacy.

In 1916 Chievitz and Meyer,¹ at the National Serum Institute in Copenhagen, introduced the cough plate as a diagnostic procedure for pertussis. They began making a vaccine from freshly isolated strains—that is, within two or three weeks of isolation. In 1924 Meyer, Kristensen, and Sørensen² reported on the prophylactic and therapeutic effect of this vaccine. They concluded that a dose of 22 billion bacteria had very little prophylactic effect. However, when this dose was given shortly before exposure or during the incubation period, the severity of the disease was diminished. For some reason not clear at the present time, the dose of 22 billion was never increased. The product, however, seemed superior to vaccine made from old stock strains.

In 1925 Dr. Thorvald Madsen, Director of the National Serum Institute in Copenhagen, came to this country to lecture at Harvard on the Danish investigations with cough plates and vaccines. His review³ of the subject is classical. Two workers in this country soon became interested in the Danish type of vaccine.

Doctor Lawson at Harvard⁴ and Doctor Sauer in Evanston⁵ began doing cough plates and making up vaccine from freshly isolated strains.

Sound experimental basis for the use of such strains was presented in 1931 by Leslie and Gardner.⁶ They showed that prolonged cultivation of the Bordet-Gengou bacillus caused it to change its antigenic complex. They described four phases through which it passed in the process of becoming "rough" or avirulent. All freshly isolated strains were in Phase I and almost all Phase I strains were highly virulent for guinea pigs. A vaccine made from Phase I strains protected these animals against a lethal dose of other Phase I strains; but

a vaccine made from Phase III or Phase IV old laboratory strains did not so protect.

Sauer⁷ soon began describing favorable results with a vaccine made from Phase I organisms. He increased the dose advocated by Madsen, introduced the use of human blood media, and harvested his growth directly into phenolized saline without washing it. Sauer vaccine is, therefore, an unwashed Phase I vaccine of high count. This is the second type of antigen that has been recommended, and I shall detail reports on it shortly.

The third type of antigen which has been used consists of extracts or lysates of Phase I *H. pertussis*. The Undenatured Bacterial Antigen of Doctor Krueger⁸ and, I believe, the Topagen of Mulford Laboratories are of this nature. As thorough field studies on the immunizing potency of these soluble antigens are either lacking or unpromising, I shall not review them. Further studies will have to be made.

FIELD STUDIES WITH PHASE I BACTERIAL SUSPENSIONS

In the chart, I have collected the reports of field studies with Phase I bacterial suspensions. In these studies this vaccine was given with intent to immunize over a period of time. There are two measures of the efficacy of an agent under such conditions: the attack rate in the group studied, and the communicability rate. Inasmuch as the *attack* rate normally varies with epidemics and with the age of susceptibles, it is useful only when a rigid control group is set up under exactly the same conditions of age, time, and place. The *communicability rate*—or the secondary attack rate as it is sometimes called—is the ratio of attack to exposure. This index is, I think, more useful in examining the data, particularly in view of the fact that there exists information on the normal communicability rate of pertussis. Biedert,⁹ Green,¹⁰ and Wheeler¹¹ (see Chart 1) found that 91, 70, and 92 per cent, respectively, of young children with negative histories contracted pertussis when exposed.

Madsen¹² reported in 1933 on the use of 22 billion cells as a prophylactic agent during an epidemic in Faroe Islands in 1920. Whereas the communicability rates are not known, and the difference in the attack rates is not significant, the mortality in the vaccinated group was one-sixteenth of that in the control group.

Reading¹³ used Sauer vaccine during an epidemic. He reports forty-nine exposures and only four cases, giving a communicability rate of 8.2 per cent. This is most remarkable. (See Chart 1.)

OTHER STUDIES

The next study mentioned, that of Doull, Shibley, and McClelland¹⁴ of Cleveland, was a very careful piece of work, rigidly controlled. The number of exposures, however, was not known, so the communicability rates could not be determined. The attack rates in vaccinated and unvaccinated groups under exactly the same conditions of age, time, place, and probable exposure, were, however, very striking. They were practically the same. This

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FIELD STUDIES ON IMMUNIZATION WITH PHASE I VACCINES WITH COMPARATIVE DATA ON COMMUNICABILITY RATES UNDER NORMAL CONDITIONS OF OCCASIONAL EXPOSURE

YEAR	AUTHOR	BRAND	DOSE IN BILLIONS	NO. VACCINATED	NO. EXPOSED	NO. CASES	COMM. RATE %	ATTACK RATE %	NO. CONTROLS	NO. EXPOSED	NO. CASES	COMM. RATE %	ATTACK RATE %
1885	Biedert												91.0
1926	Green												70.7
1936	Wheeler												92.8
1929	Wheeler	Sauer	22	1832	1374	75.0	44.6	13.8	446	438	98.1	98.1	98.1
1935	Wheeler	Sauer	80	84	49	4.2	NONE						
1936	Daughtry-Denmark	Sauer	80	392	54	13.7	NONE						14.7
1936	Daughtry-Denmark	Sauer	80-140	156	84	53.2	NONE						
1937	Sauer	Sauer	80	3974	219	7.7	NONE						
1938	Silverthorne, Friesen & Wiedemann	Own	120	747	91	2.2	16.1	27	23	85.1			
1938	Kendrick & Elderling	Own	75	1815	311	52.7	23.9	434	348	80.2			
1938	Singer, Brooks	Control	80	272	42	16.6	25.6	71	62	87.2			
1938	Siegel	Sauer NYC	80	154	5	3.2	10.6	65	43	66.1			
1938	Siegel	Health Dept	80	140	7	5.0							
1938	Siegel	Health Dept	80	148	13	8.8							
1939	Sauer	Sauer	80-100	2453	32	1.3	17.30	286	7	16.5			
1939	Singer & Faber	Control	80	346	42	11.2	18.2	36	32	88.9			

* Dose varied between trials indicated.
 † Vaccine given until no communicability reaction was obtained.

‡ Vaccine serologically Phase I but not recently isolated.
 § 12 billion cells moderately, 80 billion subcutaneously.

Chart 1

report is a very important one, and it conclusively shows that the vaccine used was not effective. The Doull vaccine, however, was made in a slightly different manner from that of other Phase I preparations in that it was washed in distilled water. Therefore, this very good bit of evidence against Phase I vaccines fails to negative the favorable reports of Sauer and others using vaccines prepared differently.

In 1936 Daughtry-Denmark¹⁵ reported on the Sauer vaccine. With a dose of 80 billion cells, she found a communicability rate of 13.7 per cent. When she based the dose on the appearance of immune bodies and found that some children required 140 billion cells, she was able to observe twenty exposures without any cases.

In 1937 Sauer¹⁶ collected all his data and found that, after 219 exposures, the communicability rate was 7.7 per cent. He lacked controls, but the normal communicability rate of this disease had been previously shown to be at least ten times the communicability rate he reported. Note the figures of Biedert, Green, and Wheeler.

In 1938 Silverthorne and his coworkers¹⁷ compared the communicability rate in a small control group with that in a group of 747 children vaccinated with 120 billion Phase I H. pertussis. Their method of preparation differed from that of Sauer only in the use of a sheep-blood medium. After ninety-one exposures only two cases of pertussis were reported in the vaccinated group. This field study is important for two reasons: in the first place the evidence is clear-cut and controlled; in the second, it indicates that human-blood medium is not essential in order to obtain a potent antigen.

The next report is that of Kendrick and Elderling.¹⁸ It is the largest controlled study that has appeared. The vaccine used was that made by the authors. Again sheep-blood medium was used. The bacterial suspension was washed once in saline. This product, therefore, differed from Sauer vaccine in two details. The total dose used was slightly less than recommended by Doctor Sauer. The communicability rate in the vaccinated group was 16.7 per cent, as compared to 80.2 per cent in the control group. This evidence is very important because of the large size of the groups studied. It is decidedly favorable for vaccination.

EFFECT OF VACCINE UNDER REPEATED AND MULTIPLE EXPOSURE
CHILDREN'S HOME (KRAMER) NO BLOOD COUNTS OR COUGH PLATES

9 Sauer Vaccine 2 years previously 80 billion	1 escape	8 had cough	6 for on average of 3 weeks 2 for one week or less.
8 positive histories of pertussis	0 escapes	8 had cough	6 for on average of 3 weeks. 2 for one week.
12 negative histories of pertussis	0 escapes	12 had cough	10 for 7 weeks or more 2 for 5 weeks

CHILDREN'S T.B HOSPITAL (SIEGEL & GOLDBERGER)

	Exposed	Typical Pertussis	Atypical Cough + Lymphocytosis	Total	Com. Rate %
Sauer Vaccine 80 billion	17	5 [†]	4 [†]	9	53
Positive Histories	16	5	0	5	31
Negative Histories	19	10	1	11	58

(X) Vaccinated 3 mos., 12 mos., 12 mos., and 16 mos. previously. (Y) All vaccinated 7 mos. previously.

Orphanage (Sauer 1939)

	Exposed	Pertussis	Com. Rate %
Sauer Vaccine 80 billion	75	6	8.0
Unvaccinated (history not given)	70	52	74.3

Chart 2

CALIFORNIA STUDIES

Last year, here at Del Monte, Doctor Singer-Brooks of the University of California¹⁹ presented her field study. She used a Phase I vaccine manufactured in California from strains isolated at the two medical schools in San Francisco. This product is similar to Sauer's in that it is unwashed and grown on human blood. Her communicability rates are quite similar to those of Kendrick and Elderling. Doctor Deamer will have more to say about this study. (See Chart 1.)

The next report is that of Siegel²⁰ in New York. He endeavored to compare the Sauer vaccine with the New York City Health Department product. There are, however, so few exposures in his study that comparison is difficult. The New York City vaccine was serologically Phase I, but was not made from recently isolated strains. The communicability rate in the control group was very low. This report does not help to clarify the issue very much.

This January, Sauer²¹ published his most recent report comparing attack rates in a vaccinated and control group. The results are similar to those he reported earlier, and furnish a local control.

The last line in the chart summarizes the results obtained by Doctor Faber and myself²² at the Stanford Children's Clinic. Since making the chart we have had two more escapes in our vaccinated group, which raises our number of exposures to forty-four, and lowers our communicability rate to 25 per cent. This is compared with a very high communicability rate of 88.9 per cent in our control group. It would appear that our results were not quite as satisfactory as some of those reported above. I have included, however, two questionable cases in the eleven listed in the vaccinated group. I shall amplify these data a little later.

I have gone into the reports summarized in Chart 1 in detail because here is the evidence on which we must judge pertussis immunization. The remaining charts contribute to a lesser extent to the problem.

RESULTS OF FAMILIAL EXPOSURES.

AUTHOR	IN VACCINATED CHILDREN				IN CONTROL CHILDREN			
	NO. EXPOSURES	NO. CASES	NO. ESCAPES	COM. RATE %	NO. EXPOSURES	NO. CASES	NO. ESCAPES	COM. RATE %
Sauer 1933	29	0	29	0.0				
Sauer 1939	27	3	24	11.1				
Kendrick & Eldering 1936	83	29	54	34.9	160	143	17	89.4
Miller & Faber 1939	11	3	8	27.3	9	9	0	100.0

Chart 3

In Chart 2 are summarized data on the effect of Phase I vaccines under conditions of repeated and multiple exposures. The clinical report of Kramer²³ is of interest in that he observed that children vaccinated with Sauer vaccine coughed no more than did children who had a positive history of whooping cough. Unfortunately, no blood counts or cough plates were done for diagnostic purposes.

Siegel and Goldberger²⁴ reported an epidemic in a tuberculosis hospital. Nine of seventeen vaccinated children who had had the Sauer product developed typical or atypical pertussis. Five of sixteen children with positive histories had pertussis, as did eleven of nineteen children with negative histories. Here it is obvious that the vaccine used was not adequate for protection against multiple exposures. Here again is evidence that second attacks of pertussis may occur. In this regard I might mention that I have observed six second attacks of the disease, all with positive cough plates. The history of the first attack was entirely reliable in five, and in the sixth instance the first attack had been proved bacteriologically.

Sauer²¹ mentions an epidemic in an orphanage in which he reports remarkable protection. In Evanston his own product has been very effective. In the light of this it is difficult to explain the above results of Siegel and Goldberger.

In Chart 3 I have summarized available material on the results of familial exposures in Phase I vaccinated and control children. Familial exposure is a fairly severe test, although perhaps not so severe as multiple exposure in an orphanage. The figures are self-explanatory. Since this chart was prepared, Doctor Faber and I have observed one more familial exposure that resulted in an escape. This would bring our communicability rate down to an even 25 per cent. If we were able to protect three out of four babies, why did we fail to protect the fourth? I think the answer lies in the variation of the normal immune mechanism. Some individuals have inferior "antibody factories." Daughtry-Denmark¹⁵ has shown that some individuals require much more vaccine than others to produce complement-fixing antibodies for *H. pertussis*. There probably also exists a small percentage of individuals who cannot be immunized at all. A child whom I saw with bacteriologically proven, severe pertussis on two successive summers is probably in this category. If an attack of the disease did not confer any protection for twelve months, I doubt if massive doses of vaccine would have succeeded.

A COMPARISON OF THE REPORTED SEVERITY OF CASES OF PERTUSSIS IN VACCINATED AND CONTROL CHILDREN.

YEAR	AUTHOR	DOSE IN BILLIONS	NUMBER VACCINATED & NUMBER OF CONTROLS	TOTAL	FATAL	SEVERE	MODERATE	MILD	ATYPICAL	QUESTIONABLE
1924	Madsen and Zachariassen	22	2094 vac.	450						
			627 cont.	405	13	4	35	410	—	—
1929	Madsen and Zachariassen	22	1832 vac.	1374	1	8	29	1336	—	—
			446 cont.	438	8	35	170	225	—	—
1937	Siegel and Goldberger	80	17 vac.	9				2	4	
			16 + hist.	5				0	5	0
1939	Singer-Brooks	80	19 - hist.	11				10	0	1
			272 vac.	7	0	0	5	1	1	—
1939	Singer-Brooks	80	256 vac.	62	0	0	10	44	6	0
			1815 vac.	52	0	2	12	17	21	—
1939	Kendrick and Eldering	75	2397 cont.	348	0	45	206	78	14	—
			346 vac.	11	0	0	4	3	2	2
1939	Miller and Faber	80	182 cont.	32	0	3	23	4	1	1

Chart 4

In Chart 4 I have summarized the reported severity of cases of pertussis occurring in Phase I vaccinated and control children. It is obvious that opinions as to degrees of severity may be readily colored by rosy hopes. Such opinions are of rather small value in a question of this kind. The differences in death rates between vaccinated and control children noted by Madsen and Zachariassen¹² are, however, striking. Singer-Brooks, Kendrick and Eldering, Doull, and Doctor Faber and myself felt, however, that the cases among vaccinated children tended to be milder.

COMMENT

On the basis of this evidence which I have reviewed I think it is self-evident that active immunization against pertussis has been accomplished with certain preparations under certain conditions. The immunity produced in the majority of children vaccinated has been of the order of that which is produced by an attack of the disease. This does not mean complete or permanent immunity, but rather increased resistance. It may be broken down under intensive exposure.

RECOMMENDATIONS

With the reports before us I think we can outline the best thing to do now. I should like to make the following recommendations:

The product used should be a bacterial suspension of recently isolated Phase I *H. pertussis*. The total dose should be not less than 80 billion bacterial cells for a child under thirty-six months of age. This is Doctor Sauer's advice, and I believe very good advice. Until we have a simple, adequate test of immunity, older children should be given larger doses empirically. The quantity of vaccine seems to be very important. I advise 100 billion cells for children of three and four years, and 120 billion cells for older children.

On the basis of our own experience and the observations of Doctor Singer-Brooks, annual re-injection with a fractional dose of vaccine is advisable. Twenty billion cells are probably sufficient for this stimulating dose.

Immunization against pertussis should be attempted at five or six months of age. I see no reason for not starting even earlier than that, though the antibody manufacturing apparatus is, of course, known to function poorly during the first months of life. The injections are best given

intramuscularly. The total dose of 80 billion cells for an infant can almost always be obtained with three injections, provided the 20 billion per cubic centimeter suspension recommended by Doctor Faber is used. The usual method of administration is 20 billion cells in one cubic centimeter the first time, 30 billion in 1½ cubic centimeters the second time, and 30 billion again the third time. Occasionally this schedule has to be altered because of reactions.

I have not seen more than a dozen sharp reactions to H. pertussis vaccine. These consisted of rather marked swelling of the arm, redness locally, and fever. These reactions caused me considerable concern for twenty-four hours. However, they yielded to iced compresses. Most of the reactions I have seen have been to the first injection of vaccine. I have then decreased the dose given at subsequent visits and administered the total dose in five rather than three injections.

Occasional local and systemic reactions are unavoidable with any protein given parenterally. As long as we give vaccine or toxoid we will have sore arms. In such cases I think one must resort to small doses and then proceed as the severity of the reaction indicates. I have seen no reactions comparable in severity to that which may occur when a fraction of a centimeter of diphtheria toxoid is given to a combined positive Schick reactor.

Phase I H. pertussis vaccine is customarily administered at weekly intervals. An interval of two weeks between injections is probably to be preferred, except during the presence of an epidemic. Intervals of three or four weeks could be used. Though this interval would unduly prolong the period of immunization, I believe the resultant protection conferred would be high.

SUMMARY

The evidence for and against the use of Phase I H. pertussis vaccines for immunizing purposes is reviewed. It is concluded that immunization can be accomplished in the majority of individuals with certain preparations. These preparations and their methods of administration are discussed.

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SYPHILIS*

COMMENTS ON ITS HISTORY

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THE history of syphilis has been somewhat aptly referred to as the negative phase of medicine; and while this opinion, based upon the futility of attempting to determine the source of the disease, is held by many, it becomes justifiable only as long as this endeavor is maintained. The constancy with which such a fallacy can persist, as the vis a tergo of many of the several recognized histories of syphilis, is as amazing as it is illogical.

Nevertheless, anyone who has written on this matter is shortly amazed at the number of individuals interested in it. To this latter group can be attributed my acceptance of an invitation from the secretary of this society to write a paper about this subject.

HOLCOMB'S WORK

If one had been asked to write on the history of syphilis yesterday, one would perhaps have been justified in the contemplation and execution of the task; but today, following the work of Holcomb, which has appeared under the title, "Who Gave the World Syphilis?" one believes the undertaking would be as unnecessary as it would be presumptuous, inasmuch as this work represents an exhaustive amount of actual personal research covering practically every known authoritative ancient

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and modern document concerned with this disease. It is unique, too, in that it has avoided the common pitfall of practically all modern works on the matter, in that these latter have been satisfied to quote from former translations under the assumption that they were both correct and complete. It would appear, following a perusal of Holcomb's work, that such renderings were neither one nor the other.

COMMENTS

In a previous paper on this subject, which was published in the *American Journal of Surgery* in 1933, we made no attempt to write a history of syphilis; but as the title, "Concerning the History of Syphilis," suggests, we were merely questioning, on a more or less logical basis, the conclusions arrived at by most of the histories then extant, namely, that European syphilis had its origin in the Americas, the which we were loath to believe.

We adopted this course because we were convinced that to attempt to arrive at any legitimate conclusion by means of data taken from ancient manuscripts, translated only with difficulty, would be prohibitive both in point of time necessary to consummate it, and from the fact that it was almost impossible to obtain access to some of the more important older works, which have become national treasures, and are, for the most part, kept in various museums. Furthermore, we believed that, assuming we had both access to the manuscripts and time to complete the work, the ultimate conclusions would be far from dependable if based solely upon this ancient, strictly documentary evidence. This conviction manifests itself in the following citations which are taken from the original paper. "Regarding the early history of syphilis, there are two main sources from which to make our deductions: (1) The writings of poems, recitations, or letters to or for patrons; (2) Treatises on disease."

PATRONS

With regard to the former, some appreciation of the conditions under which individuals existed during those times is essential to truly evaluate their work. Primarily, the patron was a man of great power and wealth, usually of the nobility. Secondly, it would appear that he was a very necessary commodity, in order that the writer might be able to publish any documents for posterity. It naturally follows that whether the patron was a rascal, as he sometimes was, or a godly man, as occasionally happened, little to nothing was published which did not meet with his approval. We must also remember that even were such a patron in sympathy with certain views of the writer, he, in his turn, was forced to be very circumspect in what he allowed to be published. In order to appreciate this, one has only to read comparatively recent history to realize how little offense in that respect was necessary to warrant the severest punishment.

CONFUSION IN TERMS

Regarding treatises on disease: While delving into the history of psoriasis some years ago, it became apparent that during the Grecian, Roman, and Arabic eras of medicine—as witness, Actius,

Hippocrates, Galen, Aegiente, Celcus, and Hali Abbas—the term "lepra" was used to designate many things, and from that time through the Middle Ages, until approximately the eighteenth century, it was used to indicate practically all diseases which were obstinate or those in which the skin presented a loathsome appearance. Furthermore, the biblical description of leprosy as being "whiter than snow" is much more nearly descriptive of a certain type of present-day psoriasis, which, it cannot be denied, is widely at variance with the clinical appearance of leprosy.

While this may be attributed to a confusion of terms, it will be admitted that medical treatises of that period would be somewhat indifferent authority upon which to base the proof of the antiquity of syphilis. In face of this, it seems incredible that the lack of a more recently acquired name should be taken as proof of the nonexistence of any given disease. One strongly suspects that leprosy, psoriasis, and at times even simple exudative eczema of extensive involvement would be classified alike, and cannot but feel that an examination of any given group of individuals of that period, segregated by law and forced to shout "unclean," would afford most medical men of today no small degree of consternation.

In this respect, in a short chapter contained in H. Fracastor's general work, "De Contagiosi et Contagiosis Morbis," devoted to elephantiasis (leprosy), he stated that in certain hospitals in Italy, which were dedicated entirely to patients suffering from this disease, he found very few true lepers, but many patients afflicted with other simple cutaneous affections interned by mistake. The immediate value of early terms in medicine might further be estimated from the term "gros mal," some believing it referred to syphilis, others that it described epilepsy. So, while we may glean much from the writings of olden times, I doubt if we can truly evaluate what was written. In other words, a great deal of time would have to be devoted to the analysis of the data; and, assuming this to be achieved to one's satisfaction, the factual data would still remain a doubtful quantity based upon the above findings.

HISTORICAL RESEARCH FOR FACTS

This mode of procedure has, however, afforded us a certain degree of criticism for failing to follow the beaten pathway of current historical research, and our previous work has been referred to as "a fair theory without any substantiation in point of fact." Nonetheless, our former convictions in this regard appear to have been adequately vindicated following a perusal of Holcomb's work in which the above contentions are fully substantiated and in which it is shown that most modern historians, delving too superficially into the matter and content with the translations of others, have permitted themselves to utilize data they would have hesitated to accept had the original works been available and properly evaluated by them; for it would appear that the work of Ruiz De Isla, including his codex, later brought to light by Montejo, upon which the American origin of the dis-

ease is mainly established following a complete translation made from photostatic copies of the original works by Holcomb, manifests that the early part of the work accuses the Americas of the origin of syphilis, whereas the latter part advocates its ancient European existence. Thus, there appears to be a strange parallel between the works of De Isla and those of Fracastor, inasmuch as the latter also implies in his first book its American origin by the question, "Is it not possible that the cause rests with those men, who . . . tried to explore unknown seas and lands opposite from ours?"

While this suggestion is discarded in a later stanza, in which it is claimed that "it would be impossible in so short a time for a contagion which is slow in its action and not easily taken to have traveled so much territory if brought for the first time to Spain in one ship." The apparent contradictions contained in these works leaves one only the more impressed with the futility of attempting the evaluation of any written material produced previous to or in medieval times. Furthermore, the absolute control of all written data which might account for the situation seems to be well established when we recognize that the earliest official records, attributing the disease to the Americas, was written by a Spanish advocate at the direct command of Charles the Fifth. This was followed, in turn, by several corroborating physicians. This situation appears to be as illogical as if the barons of the Middle Ages had deputized a physician to draw up the fundamentals of the Magna Charta, allowing the lawyers the privilege of supplementing or corroborating it at some later date. It would have been more in order had Charles deputized a physician of the times to supply factual data in the first instance.

One historian observes that the proportion of syphilis in a given peoples bears a direct relationship to the moral standing among them. This is acceptable, and upon this acceptancy alone it becomes difficult to understand the necessity of going beyond Europe to find the disease, where, if we are to believe the edicts or laws published at that time, standards of morality were so elastic as to be almost unknown. On the other hand, records of the early Catholic missionaries indicate that the standards of morality among the American Indians were exceptionally high, as witness: "Women were regarded very highly; for violation of a woman, a man was put to death."

SOME OLD EUROPEAN EDICTS

Let us now, irrespective of their value, consider a few of these old European edicts and also any data which might tend to oppose the view that syphilis did not exist in Europe prior to 1492. William Salicat, in his "Surgery," published in 1276, treats of the prophylaxis of hard and soft sores of the glans or prepuce, following coitus with a prostitute, filthy or menstruous woman.

In 1300, edicts appeared attempting to stop the spread of venereal leprosy. Edward III, in 1346, recognized the spread of leprosy through the women of the stews. In the city of Avignon, August 8, 1347, an edict provided for the inspec-

tion of brothels every Saturday to discover girls therein with any evidence of any disease contracted through venery. In 1430, Southwick imposed a fine on any stew-holder harboring any prostitute with any sickness of breening. Also, they were forbidden to admit any men who suffered from "infirmitas nefanda."

Some third of a century before the work of De Isla, Gaspar Torella, in his work, "De dolor in Pudendagra, Dialogus," replies to a query on the part of a character, as to whether it would be possible to exterminate the disease, that an infallible method would consist of appointing matrons under government authority to inspect the public women; those infected were to be segregated and placed under suitable treatment by physicians, and thus the disease would be rooted out.

Two sonnets, written by a Florentine poet in 1480, contain certain stanzas which are considered by Ozman to constitute definite proof that syphilis existed during 1480, the date of their composition. Hesser believes that the few descriptions in early literature in which there is direct relationship between a sore on the genitals and following body eruption were due mainly to the fact that doctors of the period were unwilling to blame venereal conditions for the resultant universal eruptions, and that patients undoubtedly influenced the matter in no small degree. However, he cites the observations of the French physician, De Barry of the thirteenth century, who described a condition venereally acquired which began on the genitalia and spread to the entire body. "Nam virga infecitur, et aliquando alterat totum corpus." Another case cited was that of Nicholas, Bishop of Posen, who died in 1382 as a result of morbus canceri on the genital, followed by ulcers of the tongue and pharynx. Other cases were those of King Ladislas of Poland and Wenzel of Bohemia; and, finally, we quote from an Asiatic work published in the seventh century, "The Thousand Gold Remedies," which states: "A tu ching sore is a sore on the prepuce just behind the corona in men, and on the labia in women. It is depressed and painful and looks like a chancre. A chancre is not painful." It would appear the latter observation indicates that the hard chancre was not an unknown quantity in Asia, even before the seventh century.

We believe it may legitimately be accepted that ancient leprosy was regarded from olden times as a contagious disease which was contracted from unclean or menstruous women, and it is possible, as has been contended, that either gonorrhea or chancre, or both, may have been referred to; but only syphilis can adequately explain the alopecia occasionally described in this ancient leprosy. The moth-eaten variety of syphilitic alopecia compares much too closely with this vulpina type of alopecia (named so because of its resemblance to a moulting fox) for it to be discarded as an irrelevant factor by any logical mind.

DISEASES ONCE PREVALENT IN EUROPE

Prosch, the Viennese historian, points out that up to 1495 there were four diseases largely prevalent in Europe, namely, juis persicus, fornicia, leprosy,

and *malum mortuum*; but immediately following the appearance of syphilis three of these disorders vanished off the face of the earth, and leprosy became much scarcer. It is only feasible to suppose that the former three diseases and a proportion of the latter were in reality syphilis in its normal or less virulent form. This supposition becomes more tenable when we recall that medicine in general believed at a much later date that gonorrhea and syphilis were manifestations of the same disease, and that this belief obtained until 1850, when Philippe Ricord proved them to be two separate disease entities.

DESCRIPTIONS OF THE HARD CHANCRE

A pertinent question has been one relative to the apparent lack of ancient descriptions of what would be interpreted as a hard chancre, while those of painful ulcerations with loss of tissue are of fairly common occurrence. The descriptive characteristics of the hard chancre, it cannot be denied, are conspicuously absent. This is to be expected, however, inasmuch as the clinical manifestations of the hard chancre as seen today—viz., single, indurated, painless—would undoubtedly have been a *rara avis* in that day and age; not necessarily from a lesser prevalency of the *Spirochaeta pallida*, but from a comparatively much greater incidence of the bacillus of Ducrey, due to the very mediocre standards of hygiene of this period, which would, naturally, result in a greater frequency of the incidence of the soft chancre. These lesions would be of greater moment in their eyes from the standpoint of their multiplicity, painfulness, and oftentimes destructive ulceration accompanied by the attendant suppurative adenitis; a clinical picture, compared with which the hard chancre becomes somewhat insignificant. Furthermore, under the above circumstances, a purely syphilitic infection would be of less common occurrence than the mixed infection in which the clinical characteristics of the hard chancre are only too often completely overshadowed by those of the chancroid. In this respect, a continental clinic found that a fair percentage of its clinical soft chancres gave positive syphilitic findings following the institution of routine darkfield searches in all cases of soft chancres.

AMERICAN (?) ORIGIN OF SYPHILIS

Zinzsser believes, with Fracastorius, that an unanswerable objection to the American origin of syphilis is the shortness of the period of time elapsing between the return of Columbus and the syphilis epidemic which broke out in the army of Charles in Naples. And while Holcomb is loath to accept the description of that epidemic as being that of syphilis, Zinzsser believes it was, and that it represented a new disease only in that there was a completely altered relationship between the parasite and the host, with a concomitant profound change in its symptomatology.

As was described at that time, it was possessed of a violence seldom to never observed today. It consisted of an afebrile disease characterized by pustular and vesicular eruptions accompanied by extensive ulceration. The first ulcerations usually

appeared on the genitals, although not always. The disease was often transferred from mothers to children in ordinary associations. Ulcerations resulting from the eruption sometimes covered the body from head to the knees; crusts formed and the individuals presented such a loathsome appearance that even lepers avoided them. Extensive losses of tissue in the nose, throat and mouth followed these manifestations, and following them came painful swellings of the bones, which often involved the skull. The disease caused many deaths.

Now, within a little more than fifty years, the disease had evidently changed, for in Fracastor's "De Contagione," which was published in 1546, he states that, although the contagion was still flourishing, it seemed to have changed its character since those earliest days of its appearance. "I mean that within the last twenty years or so fewer pustules began to appear, but more gummata, whereas the contrary had been the case in the earlier years. Moreover, in the course of time, within about six years of the present generation, another great change has taken place, *i. e.*, that pustules are now observed in but few cases and hardly any pains but many gummata."

IN CONCLUSION

Having in so far presented evidence which would tend to indicate, in some small measure, that syphilis might have existed prior to 1492 in areas other than the Americas, we now touch upon the educational standards of those in authority at that time which we believe may be gauged somewhat from officially recognized causes of this new disease, inasmuch as all publications of the period (as we have recounted) were under rigid censorship. The main causes given are as unique as they are interesting:

1. It was brought from the Americas by Columbus.
2. It was a visitation on Spain for the expulsion of the Jews.
3. It was a visitation by God because of certain sinful acts.

It would appear that we have appraised their clinical astuteness as somewhat superior to their mentalities when we believe, in the face of the above, that they were capable of not only classifying the manifestations of syphilis under a single name, but also of determining that the disease, even in its more normally tolerated form, had never existed prior to that time in Europe. And this in the face of the fact that the two fundamentals which are our greatest aids in diagnosis today were unknown, *i. e.*, the etiologic factor and the complement-fixation reaction.

Considering the multitudinous clinical manifestations of the disease, would it not be more logical to assume that the recognition of their being different manifestations of the same disease process was at this time slowly coming into being; a recognition which occurred primarily because of the vicious exacerbation of a long-existent and somewhat attenuate disease entity which had been catagorized previously as several diseases under many different names.

CLINICAL NOTES AND CASE REPORTS

SNAKE-BITES

A COMPACT SUCTION KIT

By ROBERT K. CUTTER, M. D.
Berkeley

AS I frequently fish the streams of the Sierra Nevada Mountains, I have had in my camping outfit the least bulky of the available effective suction snake-bite kits. On one occasion, before leaving camp in a section renowned for rattlesnakes, I tried placing this kit in various pockets; but, due to its size and hard edges, it seemed too uncomfortable an impediment to put up with. In consequence the kit was relegated, as usual, back to my dunnage bag.

That day, with the snake-bite outfit back in camp, four rattlesnakes were encountered under not too comfortable circumstances. This engendered a resolve not to be caught in a similar situation in the future.

Review of the literature confirmed the impression that effective emergency treatment required incision, tourniquet, and suction. There were available two types of suction outfits. The syringe or plunger types were more compact, but seemed impractical, as two hands are required for the proper application, and only one hand would be available if the bite were on an upper extremity. Furthermore, they are not self-retaining, and due to fatigue and the inconvenience of continuously

pulling on the plunger, it seemed obvious that suction would not be as continuous as with the bulb type.

The bulb types of suction devices available, while self-retaining, were bulky *per se*, and the packages necessary to contain the bulb and other accessories were even more bulky.

Since my needs were not met by any available outfit, I decided to try my hand at designing one. An attempt to make up an outfit with an elongated bulb having a glass mouthpiece was not satisfactory, as the bulb plus the necessary accessories was still a nuisance to carry; furthermore, the glass mouthpieces were fragile and broke in spite of various efforts to protect them.

This led to a combined suction device and mouthpiece all of rubber, and in cylindrical form so that the interior served as a container for a smaller similarly shaped suction device for use on the fingers, and the interior of the smaller "sucker" served as a container for the other necessary accessories. In other words, the accessories were contained in a capsule made up of two suction bulbs.

By making the suction pieces with reinforcing bands running horizontally and longitudinally, weight was saved and suction strengthened.

The use of the two nested red-rubber "suckers" as a capsule container proved to have several unlooked-for advantages. While they would not protect the contents against complete immersion in water for a long period of time, they would protect against rain indefinitely or complete, short immersion such as would be encountered when falling into a stream. Rubber has a clinging proclivity for cloth and does not slip out of the pocket easily.



Fig. 1

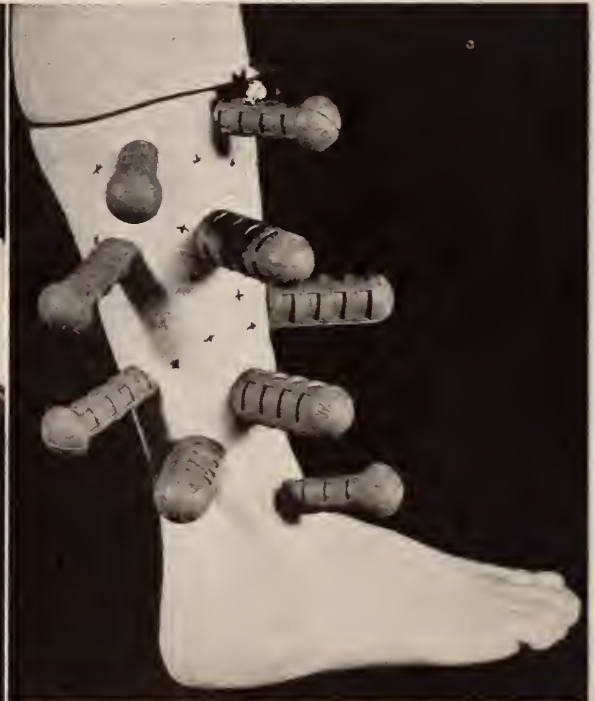


Fig. 2

Fig. 1.—Showing the two sizes of suckers which form a capsule to contain a lancet, a tourniquet, and an antiseptic.

Fig. 2.—Illustrating the use of multiple suction cups on cross incisions over the area of swelling surrounding the bite. Note that the tourniquet is tight enough to stop lymph flow without stopping venous return.

The red color is of considerable help in finding the piece if it is dropped.

This latter point was found to be of practical importance last fall when, on a deer hunt, I ran into a bees' nest and suffered multiple stings, to which I am moderately allergic. Use was made of the six cups in the three outfits which my companions and I carried, and after an hour or so I made my way back to camp with the suckers still applied. From time to time one would be knocked off, and as we were in rough, brushy country, it would have been very difficult to locate except for the red color.

As to accessories the ideal tourniquet would be a rubber band, as the object is not to stop venous flow but to stop lymph return. Unfortunately, rubber bands break unexpectedly, particularly when not fresh. The next most effective tourniquet would be a large handkerchief, but this would be too bulky to include in a compact kit. A piece of soft linen braid seemed the best compromise and was included. A vial of antiseptic and a lancet were also included.

Summary: A suction snake-bit kit is described in which the suction cups when not in use form a compact capsule container for accessories.

Fourth and Parker Streets.

AIRCRAFT AS DISEASE CARRIERS

By HAROLD L. SCHLOTTHAUER, M. D.

Tehachapi

THE great increase in flying has frequently raised the question as to the possibility of transmission by aircraft of diseases and disease-bearing insects over large areas. This possibility was directed to my attention by four unusual cases following within a period of a few weeks the arrival at Muroc of a group of military planes reported to have come directly from South America by way of Panama. These were cases of acute illness produced by the bite of an insect previously unknown to the residents of the Mojave Desert.

REPORT OF CASES

CASE 1.—G. M. White, male, age one year. Was bitten on an arm and a leg while lying in its crib during the early evening hours, and within one-half hour the patient's body was covered with urticarial wheals. After one hour the axillary temperature was 103 degrees Fahrenheit. Hot magnesium sulfate compresses were applied to the site of the bites which, in twelve hours, were greatly swollen. For three days the temperature remained near 103 degrees, the tongue was swollen, and the child was very lethargic. On the fourth day the temperature returned to normal and the manifestations of allergy disappeared, but the lethargy remained for two weeks. The local lesions became chronic ulcers, which healed in about three months.

CASE 2.—J. H. White, female, age 34, housewife. Was bitten on the right hand while in bed at night. The immediate symptoms were dyspnea, headache, vomiting, fever (102 degrees) and generalized urticaria, which persisted for over two hours. The following morning the patient was normal except for marked swelling of the affected hand, which subsided in three days.

CASE 3.—B. J. H. White, female, age 9. Was bitten on the right cheek at 1 a. m. while asleep in bed. She was

immediately seized with vomiting, headache, fever, and a generalized urticaria. After about one-half hour she became lethargic and could be awakened only with difficulty. By morning the symptoms had subsided. The affected cheek remained swollen for three days.

CASE 4.—M. H. White, female, age 65, housewife. Was bitten on the arm at 7 p. m. while sitting on a chair under a tree in her yard. She immediately became nauseated, developed a fever (102 degrees), chills, and generalized urticaria. The tongue was swollen and made talking nearly impossible. The immediate symptoms disappeared gradually after two hours except for the fever, which persisted for two days. The site of the bite on the arm was swollen and painful for one week.

COMMENT

Specimens of these insects were taken, some while in the act of biting, and sent to Dr. W. B. Herms, head of the Department of Entomology and Parasitology of the University of California, for identification. He found them to be *Paratriatoma hirsutus* Barber, recently described members of a family of blood-sucking, cone-nose, many of which are vectors of Chaga's disease or American trypanosomiasis, most commonly seen in South America. The cases cited, however, have no resemblance to Chaga's disease. After observation for approximately one year, these patients have shown no further symptoms and no demonstrable pathology. No more of the insects have been found.

115 E Street.

HIGH VITAMIN THERAPY FOR THE RELIEF OF TIC DOULOUREUX

By EDWARD MATZGER, M. D.

San Francisco

THE original clinical research of Dr. Henry Borsook, professor of biochemistry at the California Institute of Technology, for the treatment of tic douloureux¹ was so brilliant and conclusive that I took advantage of the opportunity to use it on two patients.

The "Borsook technique" is: To commence treatment with daily intravenous injections of 10 milligrams of thiamin chlorid. This is supplemented by 7½ to 10 U. S. P. units of liver extra intramuscularly, three times weekly. In addition, we prescribe 6 drams of the rice bran extract, marketed by Galen Company of Berkeley, California. This material contains the whole B complex and affords 200 I. U. of B₁ to the dram. The patients are placed on high vitamin low carbohydrate diet, and are asked to supplement the A and D intake by taking one of the fish-liver oils in moderate amounts. The latter is perhaps not necessary, but it gives a better balance.

We find that progress is very slow. There may be no significant reduction in pain for two or three months. For those patients who show no response in three months, we increase the dose of thiamin chlorid to 100 milligrams daily. Treatment is continued in all cases until the patient is free of pain for two months. The daily injections are then

¹ J. A. M. A. in press.

tapered off by giving, first, three a week, then two a week, then one a week, over the course of several months. Even after that relapses may occur, but these usually respond to short periods of intensive treatment."

I have modified this in that I secure adequate vitamin A intake by having the patients take a can of S & W carrot juice three times a week. (S & W contains 24,000 units of vitamin A per can.)

REPORT OF CASES

CASE 1.—Mrs. J. H., age 59. Has had typical tic douloureux symptoms on the right side of her face since 1932; pain under right eye, angle of mouth, and temple. The character of the pain is sharp, and shooting pains recur at very frequent intervals. She had four alcohol injections: the first one, in 1933, was followed by eighteen months' partial relief; the second injection, in 1935, with less than six months' partial relief; the third, in 1937, and the fourth, in 1938, with no relief of pain, although there was an annoying anesthesia. On February 2, 1939, I started in with the "Borsock technique" and there was continuous improvement from the start. In June, July, and August there was a complete cessation of pain, and the patient discontinued treatment. Within a week from the beginning of the treatment she experienced a feeling of well-being, had increased appetite, normal bowel movements, and abundant energy. She was able to eat without pain, and thought she was entirely cured. There was a relapse, however, in November, 1939, which responded slowly to additional therapy. While she is not completely free of pain now, life is bearable, and there are no further thoughts of suicide.

1 1 1

CASE 2.—Mr. W. W. P., age 59. Atypical bilateral neuritis with muscular twitching. Onset, twelve years ago. Trigger area was on left side of lower lip, and pressure or cold wind, or eating or talking, would cause shocks of pain, radiating from trigger area to temple. Totally incapacitated since 1934. The right side was injected in November, 1938, with only two months' relief of right-sided pain. The patient came in for treatment on June 2, 1939, and under the "Borsock technique" was progressively better until 100 per cent relief of pain was secured in August of 1939. Since this period he has remained symptom-free on "Galen B" by mouth alone, and the twitching is greatly diminished. Last examined on February 1, 1940, and has suffered no relapses.

COMMENT

This high vitamin regimen has relieved the pain of tic douloureux in these two patients, and has banished thoughts of suicide from one patient (Mrs. J. H.), and made life worth living for the other. In addition to the relief of pain, there was a marked improvement in general health and nutrition. This second feature was so striking that I have used this identical technique in the treatment of other groups of patients. These findings will be reported later.

909 Hyde Street.

FURUNCLES AND CARBUNCLES*

By JOHN BLEMER, M. D.
Danville

IN a general practice there is occasion to treat many cases of furuncles and carbuncles. Not believing in the immediate incision method of treatment for these infections, an ultra-violet light

routine has been used for the past six or seven years, and has brought about the discard of the scalpel and excellent results. In consideration of the degree of pain and length of time required for recovery, it makes for fewer dressings and less loss of time as well as less danger of spread of infection or resultant scarring than results from crucial, stellate or other types of incisions.

There are all gradations of furuncles and carbuncles, depending upon the site and previous treatment before seen by the physician. In considering the carbuncle as most severe, it is usual that hot compresses or home-remedy poultices have been applied and the area has "come to a head," but is not fluctuant. Immediately it is washed with an alcohol swab and exposed to ultra-violet light at a distance of 10 to 14 inches for two or three minutes. The surrounding area must be protected with toweling and the light directly centered over the carbuncle. Care must be taken to prevent harsh or unnecessary erythema. Following the exposure a salve, composed of ergot, 10½ grains, phenol, 7½ grains, zinc oxid 22½ grains in a suitable base, is applied with a sterile gauze dressing. Usually two of these treatments are sufficient to soften the entire area, and the central cores are easily picked out with sterile forceps. Any bleeding from the surrounding skin or central core is an indication to stop removal of necrotic tissue. During the next few days the area drains and heals. Dry dressings are changed daily while the drainage is present. The simpler furuncles may be quickly aborted following this routine. Following are a few of the typical cases treated in the past two years:

Name	Diagnosis	Number of Treatments	Exposure in Minutes	Results
B. R.	Furuncle, neck	3	3	Cured
B. O.	Furuncle, neck	2	2.5	Cured
R. L.	Furuncle, forearm	4	4	Cured
E. L.	Furuncle, thigh	3	4	Cured
M. J.	Furuncle, cheek	2	3	Cured
E. I.	Furuncle, arm	3	3	Cured
E. R.	Furuncle, elbow	2	3	Cured
A. L.	Furuncle, abdomen	3	2.5	Cured
A. K.	Furuncle, jaw	3	4	Cured
M. I.	Furuncle, forearm	3	5	Cured
M. F.	Furuncle, abdomen	2	2.5	Cured
C. E.	Furuncle, neck	3	4.5	Cured
M. C.	Furuncle, wrist	2	4	Cured
E. S.	Furuncle, hand	2	4	Cured
W. C.	Furuncle, upper lip	5	2.5 or 3	Cured
J. C.	Furuncle, lip and chin	6	2.5 to 8 min.	Cured
W. M.	Furuncle, upper lip	2	3	Cured
F. M.	Carbuncle, neck	4	4	Cured
A. G.	Carbuncle, neck	5	4	Cured
J. J.	Carbuncle, thigh	4	4 to 8	Cured
E. K.	Carbuncle, neck	5	5	Cured

COMMENT

In the past few years there has been produced a thin window bactericidal lamp, combining ultra-violet and infra-red qualities. This type of lamp eliminated the very objectionable features of the old quartz mercury lamp by limitation of the burning effect on the skin. The strong radiation of the thin window lamp in the bactericidal range of ultra-violet allows close approximation to the skin for much longer periods of exposure without danger of blistering or burning. This type of lamp has been used in my office routine the past three months, and its superior qualities over the older treatment are shown by the following cases.

* A comparative study of the treatment of furuncles and carbuncles by ultra-violet light, and the thin window bactericidal lamp.

Name	Diagnosis	Number of Treatments	Exposure in Minutes	Results
T. F.	Cellulitis folliculitis right fifth finger following thorn	5	10	Healed
J. D.	Furuncle, face	2	5	Healed
J. S.	Furuncle, scrotum	3	5	Healed
Miss W.	Furuncle, leg	3	5	Healed
J. S.	Carbuncle, neck	3	5	Healed
W. B.	Furuncle, knee	2	6	Healed
Mrs. T.	Furuncle, forehead	3	4	Healed

In the last two cases the patients were highly susceptible to sunburn. Neither are able to be exposed in swimming or outdoor work without blistering. There were small areas of scaling in both cases and the infection cleared rapidly.

HIPPOCRATES' APHORISMS*

By MOSES SCHOLTZ, M.D.
Arcadia

SECTION TWO (Continued)

30. When illness starts and when it dies,
Symptoms abate, but at the peak they rise.
31. When a convalescent's appetite is strong—
And yet he fails to gain—
It's an ill portent that something must be wrong.
32. The sick who hold their appetite in early stages
But do not gain, will lose it later on:
While those who lose their appetite quite early
Regain it later and profit thereupon.
33. It augurs well, if the patient's mind is sound,
And he accepts all food that's offered him;
But, if the contrary conditions do prevail,
The chances of recovery are slim.
34. There is less danger, if an illness is
In good accord with the patient's age, his
wonts,
His constitution and the current season;
If not, the patient greater risks confronts.
35. If the umbilical and hypogastric regions
Preserve their fullness, it augurs well indeed;
But if they are depleted, it's a bad omen,
And purging may to a disaster lead.
36. A healthy person quickly could
Impair his strength through purging or bad
food.
37. The purging drugs do ill assort
With persons whose health is their forte.
38. A food or drink, which is of lesser value
But is more palatable, is the one to choose
Rather than one, which is of greater value,
But which the patient's palate may refuse.
39. Old people do not have as many ailments
As do the young, but ailments of the old
Are apt to drag and last good many years,
Until the aged leave their earthly mold.
40. Catarrhs and inflammations of the nose
In the old people linger and ne'er close.
41. To those who suffer from attacks
Of fainting, frequent and severe,
Without an apparent cause,
A sudden death is ever near.
42. In a severe attack of apoplexy
A cure is almost impossible to get;
And even in a mild attack of it
The poor results are much too often met.
43. Of those who've been suspended by the neck
And are in state of coma, but not quite dead,
Those showing foamy bubbles at the mouth
Will not recover: they're on their death-bed.
44. Those who by nature are excessively obese
Much sooner than the slender ones de cease.
45. Epilepsy in the young is cured most often by
A change of air, of residence or mode of life
they try.
46. If a patient chances to develop pains
In two distinct and different locations,
The weaker pain diminishes and wanes.
47. All pains and fevers start and flare
More often at the time of pus formation
Than after pus is formed and settles there.
48. If body movements keep one ill-distressed
Because of pains, he can be eased by rest.
49. Those who are well accustomed to hard
labors,
Though sapped by lack of strength or waxing
years,
Do stand them better than the young and
strong,
Who are not used to toil—so it appears.
50. The things accustomed to are borne better,
Tho' they may be worse than the things un-
used;
Yet on occasion, if need be, a change
To a new thing cannot be well refused.
51. A change of any factor in the body,
Be it in feeding, purging, heat or cold,
Should be made gradually and slow,
As sudden and excessive things bring woe.
52. If a treatment, based on a well-considered
reason,
Does not produce the good effect it should,
The healer should not change his plan of
treatment,
As long as the indications still hold good.
53. Some laxity of bowels in youth
Is better than a constipated state.
But the reverse is true in later years,
When constipation's a near-normal rate.
54. A large body in young age is shapely and be-
coming,
But in old age it's untoward and speeds
succumbing.

* For other aphorisms, see CALIFORNIA AND WESTERN MEDICINE, March, 1940, page 125; April, 1940, page 179; May, 1940, page 231.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HARRY H. WILSON.....President
HENRY S. ROGERS.....President-Elect
LOWELL S. GOIN.....Speaker
PHILIP K. GILMAN.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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OFFICIAL NOTICE

PROPOSED AMENDMENT TO CONSTITUTION OF CALIFORNIA MEDICAL ASSOCIATION PROVIDING FOR LIFE MEMBERSHIP*

Resolved, That Article IV of the Constitution of this Association, California Medical Association, be and the same hereby is amended by adding to Section 1 of said Article IV a new subdivision, namely, Subdivision (e), entitled "Life Members," and reading as follows:

"(e) LIFE MEMBERS

"Qualifications: Life members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who (1) have been active members of this Association continuously for a period of twenty (20) years or more and are more than fifty (50) but less than sixty (60) years of age and have tendered to this Association a life membership fee of one hundred fifty (150) dollars; or (2) have been active members of this Association continuously for twenty-five (25) years or more and are more than sixty (60) but less than sixty-five (65) years of age and have tendered to this Association a life membership fee of one hundred (100) dollars; or (3) have been active members of this Association continuously for a period of twenty-five (25) years or more, are more than sixty-five (65) but less than seventy (70) years of age and have tendered to this Association a life membership fee of fifty (50) dollars; or (4) have been active members of this Association continuously for twenty-five (25) years or more and are more than seventy (70) years of age. Those active members falling within Classification 4 need not be recommended by any component county society, but are eligible to life membership on direct application to the Council. The Council may not elect to life membership any active member whose membership has not been continuous or who has ever been censured, suspended or expelled from the American Medical Association, this Association, any state medical association which is a constituent unit of the American Medical Association, or any county medical society which is a component part of this Association or a unit of any other state medical association.

"*Obligations and Rights.*—Life members shall not pay dues and shall not be liable for assessments of any kind or nature. If active membership in good standing is main-

tained in his component county society, each life member shall have the right to vote, to hold office, and shall have all other rights and privileges of the Association. If active membership in his component county society is not maintained, the rights and privileges of a life member shall be those of a retired member."

COMMITTEE ON PUBLIC HEALTH EDUCATION†

The Committee on Public Health Education reports progress on two projects of major importance—the essay contest for high school and junior college students, and plans for a motion picture, depicting the modern beneficial phases of the practice of medicine, to be shown before schools and organizations.

During the past month, approximately five hundred schools, including parochial schools, were notified of the essay contest, which closes on November 1.

Plans for a scenario-writing contest, upon which the motion picture will be based, are going forward and will be announced soon.

Several requests by the committee to the American Medical Association that the pamphlet, "A Chiropractic Catechism," be reprinted, exposing the fallacies of chiropractic, finally were successful and a supply of these pamphlets were ordered from the American Medical Association for distribution to college students under supervision of the college physician. This augments your committee activity, previously reported, of supplying college students with beneficial information regarding the medical profession.

The Committee on Public Health Education assumed the duty of handling publicity for the California Medical Association annual meeting at Coronado and reports a very successful outcome. San Francisco and Los Angeles newspapers, as well as San Diego papers and the wire news services, were represented at the convention and were aided in their work by the public relations counsel, Ross Marshall.

Prior to the convention, the Public Relations Counsel secured advance copies of many of the speeches and wrote advance stories on the same. This procedure resulted in additional favorable publicity.

The Committee exhibited a poster display at the convention, illustrating its work.

The Committee secured the services of Dr. Mast Wolfson of Monterey to speak before the Santa Cruz Kiwanis Club on April 30. Doctor Wolfson's talk was reported to have entirely reversed an unfavorable attitude on the part of some club members inspired by four previous speakers who had criticized the medical profession.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Dewey R. Powell, Stockton; Harry H. Wilson (ex officio), Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUCKER 2312), or 244 Kearny Street, San Francisco (telephone YUKON 2212).

† For complete roster of officers, see advertising pages 2, 4, and 6.

* First printing of this constitutional amendment in April 1940 CALIFORNIA AND WESTERN MEDICINE Supplement, on page 44. See also June issue, on page 280.

Your Public Relations Counsel was instrumental in ending a dispute of three years' standing between the Los Angeles County Medical Society and newspapers of that county regarding professional cards.

The Public Relations Counsel also conferred with members of the medical society in San Bernardino County regarding unethical marketing of an alleged tuberculosis cure in that county and gave his advice as to the proper course to be pursued.

Talks explaining the program of the Committee on Public Health Education were made by the Public Relations Counsel before the Mendocino-Lake, Ventura, and Sacramento medical societies.

The Sonoma County Medical Society within the past few weeks inaugurated a weekly radio broadcast to continue for forty-eight weeks from the station at Santa Rosa, utilizing the set of approved American Medical Association speeches secured by the Committee on Public Health Education.—R. M.

CALIFORNIA PHYSICIANS' SERVICE†

California Physicians' Service is continuing to enroll members at a satisfactory rate. During the month of June approximately 2,000 new members were secured, bringing the present total to about 14,500. Payment of bills for services rendered during April has just been completed. The unit value for that month was \$1.25, a fact which gives the Trustees of California Physicians' Service a great deal of concern. A study is now being made of the services rendered during this and previous months to determine, if possible, what factors have contributed to the large number of units of service (9,900) rendered during the month of April. During January, February, and March, the large number of respiratory infections was primarily responsible for the volume of service rendered, and it was anticipated that during April there would be less of this type of care necessary, an anticipation which does not seem to have been realized. The monthly study being made will reveal the exact rôle played by respiratory infections in April, and further study will suggest possible changes in group selections, stricter adherence to our policy of non-liability for preëxisting conditions, etc. It is impossible to predict, but the hope is that experience for May will permit the payment of an increased unit value.

† † †

During its formative months, and in spite of the note on each bill form, California Physicians' Service has accepted bills for payment even though they were not received by the fifteenth of the month following the month in which the service was rendered.

With the present volume of business—1,500 patients per month seen by some 1,200 physicians—this practice can no longer be continued. *Therefore, effective for June bills, no bills will be accepted for payment and included in the computation of the unit value for any month unless they are received at the office of California Physicians' Service by the fifteenth of the month following the month in which the service billed for was rendered.*

Only in this manner can bills be paid expeditiously and office administrative expense be held within reason.

† Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. Alson Kilgore, M. D., secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

In accordance with approval voted by the House of Delegates at Coronado, California Physicians' Service has proceeded with plans for the development of a program of medical care for public assistance recipients. The first step in this direction has been accomplished, namely, the inclusion in relief legislation enacted at the special session recently concluded of a provision authorizing relief officials to contract with a nonprofit agency for medical care. An excerpt from the Act reads as follows:

"Sec. 6.7. With money from this appropriation, not to exceed one per cent of the total sum appropriated, chargeable to the 82 per cent classification, the Relief Administrator and the Relief Commission may contract with any nonprofit medical or health service corporation organized under the laws of this State for the rendition of medical and health services to any person and his family eligible for assistance from this appropriation."

It is significant to report that legislators in both the Senate and Assembly, representing all schools of thought, received representatives of California Physicians' Service most favorably, and evinced considerable interest in the proposals made. The amount of money which could be used in accordance with the provision quoted above would not exceed \$220,000. This sum is not adequate to provide medical care to even the extent covered by the State Relief Administration during the last six years. However, the legislation places California Physicians' Service in a position of negotiating with the State Relief Administration, according to the intent of the legislature, for the provision of such services as may reasonably be produced with the appropriation available. Plans are now being worked out for the presentation of a proposal to the officials of the State Relief Administration.

COUNTY SOCIETIES†

CONTRA COSTA COUNTY

The regular monthly meeting of the Contra Costa County Medical Society was held on Tuesday evening, June 11, at the Hotel Carquinez, Richmond.

Program:

8:00 p. m.—Motion Picture: *Pentothal Sodium for Intravenous Anesthesia*.

8:45 p. m.—Business Session.

9:00 p. m.—Discussion: *Medical Care in Disaster Relief*, Mr. Henry M. Baker, Assistant Manager of the Pacific Branch Office of the American National Red Cross. His discussion included the place of the medical group in the disaster preparedness and relief picture.

The next meeting of the Society will be in September. There will be no meetings during July and August.

L. ABBOTT HEDGES, *Secretary*.

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MENDOCINO-LAKE COUNTY

The June meeting of the Mendocino-Lake County Medical Society was held in the Redwood Coast Hospital, Fort Bragg, with Dr. Dallas L. Wagner presiding.

Doctor Wagner introduced Dr. Henry S. Rogers, President-elect of the California Medical Association, who gave a brief report of the annual session held at Coronado.

Mr. Ben Read, Secretary of the Public Health League, spoke on the legislation affecting the practice of medicine in California as dealt with in the last session of the Legislature.

A motion approving the coöperation of our State Senator and State Assemblyman, Mr. Biggars and Mr. Byrnes,

† For roster of officers of component county medical societies, see page 4 in front advertising section.

and recommending that letters of appreciation be sent to each of them was passed.

Mr. Ross Marshall of the California Medical Association Committee on Public Health Education gave a comprehensive talk regarding the work done by the Committee.

Dr. William Stegeman of Santa Rosa was then introduced. His subject was *Urology as It Presents Itself to the General Practitioner*. Numerous slides and x-ray pictures were used.

It was decided to hold the next meeting at Willits some time in August.

ROYAL SCUDDER, *Secretary*.

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PLUMAS-LASSEN-MODOC

A meeting of the Plumas-Lassen-Modoc County Medical Society and ladies was held in the banquet room of the Grand Café in Susanville the evening of May 25.

Following a steak dinner, Dr. Martin Debenham of San Francisco gave a talk on *Immediate Suturing of Tendons in Traumatic Wounds*; a subject of great interest to the industrial surgeons of our district.

BERNARD S. HOLM, *Secretary*.

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SAN JOAQUIN COUNTY

The regular meeting of the San Joaquin County Medical Society was held on June 6 at Pete's Place, Valley Springs. According to custom, this meeting was sponsored by and conducted by the Lodi members of the San Joaquin County Medical Society. Due to the absence of President Hugh Bolinger, Vice-President, Dr. Ray Owens was in the chair. Due to the nature of the meeting, there was no business presented. After a very enjoyable dinner, our guests of the evening were introduced. The guests were George H. Kress, Secretary of the California Medical Association; Karl Meyer, Director of the Hooper Research Foundation, University of California; Paul de Kruif, noted author; and Mr. Riley from Cleveland, Ohio. Each of the guests spoke briefly on various phases of politics and medicine. A brief report was given by Dr. Dewey Powell on the recent Coronado convention.

As usual, the Lodi members presented a very enjoyable evening, and the thanks of the County Society were given to the Roma Winery, Shewan-Jones Winery, and East Side Winery of Lodi for their share in the various festivities. The meeting was adjourned at 11:30 p. m.

G. H. ROHRBACHER, *Secretary*.

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SOLANO COUNTY

At a meeting of the Solano County Medical Society held on Tuesday evening, June 11, in the office of President Madeley, it was voted that members of the Society should examine Girl Scouts, who should present to their family physicians their Girl Scout cards.

In recognition of the worthy purposes of the Girl Scouts movement, it was agreed that our members would not charge regular fees for the examinations.

However, since the representatives of the Girl Scouts had stated the sum of 75 cents per examination could be paid, it was agreed that this should be paid by the Girl Scouts organization to the Solano County Medical Society.

The Solano County Medical Society, in turn, would then donate the sum so received to the local Red Cross; the reduction in the professional fees and the donation to the Red Cross being an expression of the willingness of the Society to coöperate in the good work.

JOHN W. GREEN, *Secretary*.

VENTURA COUNTY

The regular meeting of the Ventura County Medical Society was held at Saticoy on Tuesday, May 14, with Doctor Barker presiding, and eighteen members and six guests present.

Dr. W. S. Clark introduced Dr. Charles Lamb of Santa Barbara, who spoke on *Acrodynia*.

The meeting for June is to be a joint one with the Auxiliary, dentists, druggists, and nurses of the county.

A. A. MORRISON, *Secretary*.

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YUBA-SUTTER-COLUSA

The first meeting of the reorganized Yuba-Sutter-Colusa County Medical Society was held at the Hotel Marysville on Tuesday evening, June 4, with Dr. Benjamin F. Miller presiding.

Of the six members of Colusa County, Doctors Charles F. Keith, Joseph E. Tillotson, and G. W. Desrosier were introduced and welcomed into the new Yuba-Sutter-Colusa unit (formerly the Yuba-Sutter County Society). Doctor Keith has for some time been the president of the Yolo-Glenn-Colusa County Medical Society, and Doctor Desrosier the retiring City Health Officer of Colusa.

Visitors present were: Doctors Cary of Gridley, Fratis of Yuba County Hospital, Lentz of Sutter County Hospital, and Frank MacDonald of Sacramento, Councilor of the Eighth District of the California Medical Association, who gave us a brief report for the Association Council, explaining its reorganization to lighten the work of the Secretary's office. Doctor MacDonald stressed (1) that the county medical societies in northern California are generally poorly organized over an area comprising of around 400 square miles of territory. And that at the recent meetings of the California Medical Association at Coronado no county society north of our local society sent a delegate to the convention. Dr. Stanley Parkinson, the Yuba-Sutter delegate, was present at this convention, but at present is on vacation.

(2) That a Woman's Auxiliary to the Medical Society should be formed locally. Doctor MacDonald explained the work of such an organization and stated that our society is one of the few in the State in which a Woman's Auxiliary has not been organized. It was decided to begin working on a plan to interest wives of local physicians in forming a Woman's Auxiliary.

George Halkyard, retired local druggist, was present and presented a plan for a physicians' telephone exchange, which would be conducted to handle calls especially in the doctors absence, and in case of emergencies. This was taken under advisement by the Society.

President Miller stated that the local Chamber of Commerce have asked for a joint meeting with the Medical Society, having the Medical Society put on the program at the meeting. President Miller appointed Dr. John Duncan to work out the details for such a joint meeting.

A speakers' bureau was discussed by Councilor MacDonald and Doctors Hamilton, Swift, Miller, and Loomis. The plan is to set up a speakers' bureau, to be composed of physicians who are capable and willing to talk on medical subjects before other clubs and organizations in the community which frequently call upon members for such speeches.

A letter from the Yuba-Sutter League of Women Voters was read by the Secretary, which related to a petition to the mayor and members of the Council of the city of Marysville, requesting that "Marysville shall operate under the Yuba-Sutter Bi-County Public Health Unit."

The Health Department of the city of Marysville was discussed by Doctors Kimmel, Hennessy, and Miller, and

the Society as a whole strongly favoring coöperation of the city of Marysville in the establishment of a public health unit.

Dr. R. Lucian Hamilton, Chairman, reported for the Hospital Relations Committee and stated that, due to the new law which prohibits hiring nonregistered nurses, the situation is becoming very acute, and that it is impossible to secure an adequate number of qualified nurses for the Yuba County Hospital.

Reference was made to the fact that the resident physician at the county hospital is not adequately covered with malpractice insurance and that steps are being taken to secure proper coverage. Ward rounds are held at the Yuba county hospital every Friday morning at 9 a. m., and all local and visiting physicians are urged to attend. Doctor Hamilton further mentioned that a physician must register in every county in which he practices his profession.

Dr. Philip Hoffman, Chairman, reported for the Tuberculosis Committee, stating that the supervision of the work had been delegated to Doctor Linstrum. Doctor Linstrum reported that Doctor Hoffman had completed skin testing in the high school in Marysville, and that Doctor Didier had done the skin testing in Wheatland. Doctor Desrosier reported on the work done at Colusa last fall. Doctor Keith stated that they have carried out a complete tuberculosis program in Williams this spring. Doctor Hennessy stated that the tuberculosis program and the Tuberculosis Association in Yuba County are now functioning very fine and coöperating smoothly with the Public Health unit, but that Sutter County is not coöperating. Request was made that the Medical Society instruct its secretary to write to the Sutter County Tuberculosis Association, asking that they express to us their policy. It was so ordered and subsequently a letter was sent to the president of Sutter County Tuberculosis Association. Doctor Hennessy further stated that it would facilitate the work of the tuberculosis examinations if the x-rays were filed in a central location and offered to file them in his department. Dr. Romaine B. Whitney reported on the Yuba-Sutter Venereal Clinic and stated that this clinic was newly organized and functioning smoothly, but he vigorously condemned the Social Service of the department as being inadequate and felt that it was endeavoring to build up as large a free clinic as possible without due regard to the fact that some of the patients were able to pay for the services rendered.

Doctors Delamere and Duncan reported for the Agricultural Workers' Health and Medical Association Migrant Camp Clinic, south of Yuba City.

The speaker of the evening, Dr. Sterling Bunnell of San Francisco, discussed *Reconstruction of Hands*. Doctor Bunnell illustrated his treatment and handling of injured hands by lantern-slide drawings and actual photographs before reconstruction and following to show the results obtainable.

The meeting was adjourned, and is at the call of the President during the summer months. Following the meeting a supper was served. LEON M. SWIFT, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (60)

Alameda County (5)

B. K. Christopoulos, *Oakland*
Lella Stevens Craig, *Berkeley*
Ernest O. Gunderson, *Berkeley*
Harry P. Krummes, *Oakland*
Walker M. Wells, *Oakland*

Butte-Glenn County (1)

C. M. Guernsey, *Chico*

Fresno County (2)

William H. Riley, *Fresno*
Lawrence A. Solberg, *Kerman*

Los Angeles County (22)

Albert J. Campbell, *Pasadena*
Thomas P. Downey, *Los Angeles*
Clifford Earl Easley, *Torrance*
Sigrid Ann Esbern, *San Fernando*
Don B. Gibboney, *Los Angeles*
Willard M. Gobbell, *Van Nuys*
Carl F. Grunewald, *Pasadena*
Frederic W. Haigh, *Los Angeles*
Trester S. Harris, *Los Angeles*
Willis L. Jacobus, Jr., *Los Angeles*
A. Laurence Kiefer, *Los Angeles*
Grant Lund, *North Hollywood*
David A. McCoy, *Los Angeles*
Cyril L. Mitchell, *Santa Monica*
Clyde V. Nelson, *Van Nuys*
Leslie S. Orleans, *Los Angeles*
Paul H. Osiek, *Pasadena*
Charles E. Pancoast, *Los Angeles*
Maurice S. Priver, *Los Angeles*
Bernard H. Rosser, *Los Angeles*
Ruth J. Temple, *Los Angeles*
Julius Ziegler, *Los Angeles*

Sacramento County (1)

Erle M. Blunden, *Fair Oaks*

San Diego County (4)

John W. Flaiz, *Vista*
John Crawford Holman, *San Diego*
Saul Ruby, *San Diego*
A. Ragnar Stadin, *National City*

San Francisco County (11)

Robert B. Aird, *San Francisco*
Dana V. Clark, *San Francisco*
John F. Huffman, *San Francisco*
Helen Marie Johnson, *San Francisco*
Richard D. Loewenberg, *San Francisco*
James Clifford Long, *San Francisco*
Charles Dalliba Marple, *San Francisco*
John M. Nagle, *San Francisco*
Samuel R. Sherman, *San Francisco*
Philip Vogel, *San Francisco*
Otto R. Wallerstein, *San Francisco*

San Luis Obispo County (3)

Gilbert S. Coltrin, *San Luis Obispo*
C. C. Najjar, *San Luis Obispo*
Edward C. Sherman, *San Luis Obispo*

Santa Clara County (2)

Gordon Billingsley, *Saratoga*
H. Weldon Wilkinson, *San Jose*

Santa Cruz County (1)

John D. Fuller, *Santa Cruz*

Sonoma County (4)

Ralph V. Harr, *Santa Rosa*
William N. Makaroff, *Guerneville*
William E. Rogers, *Santa Rosa*
Thomas M. Torgenson, *Santa Rosa*

Stanislaus County (1)

James E. Thompson, *Newman*

Tulare County (2)

William S. Neal, *Visalia*
Roy F. Ruth, *Woodlake*

*Yuba-Sutter-Colusa County (1)*Charles B. Kimmel, *Marysville***Transfers (3)**

George F. Keiper, Jr., from Los Angeles County to Tulare County.

Henry John Lane, from San Francisco County to Santa Clara County.

Richard A. Westsmith, from Los Angeles County to San Diego County.

In Memoriam

Vener, Hyman Israel. Died at Los Angeles, May 23, 1940, age 40. Graduate of the University of Illinois College of Medicine, Chicago, 1925, and licensed in California the same year. Doctor Vener was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARY**Rexwald Brown*****1878-1940**

Dr. Rexwald Brown, a physician and surgeon who applied the spirit of his profession's great oath of service to the whole scope of his living, died in his Santa Barbara home Friday morning.

Throughout his life he fought vigorously for what he thought was right, without malice toward his opponents and without expecting reward from his cause. He accepted his unusual abilities and his many opportunities as responsibilities. His great reward was an unlimited capacity for kindly friendship.

For many years Doctor Brown served on Santa Barbara city and county boards, commissions, and committees. He did not count the cost in time and energy. He did not stop to consider the effect of an unpopular cause on his personal affairs. As a citizen his attitude toward unhealthy public growths and conditions was the same as his attitude, as a surgeon, toward disease. He accepted knowledge and conviction as responsibility. He did not hesitate to do the best he could because he might escape responsibility by doing nothing.

When such a man dies it is not necessary to say that he was beloved. To the credit of mankind, such a character is always beloved—and, more than that, it is respected.

Evidences of Doctor Brown's contributions to his community will live long in Santa Barbara's health service, organized charities, juvenile courts, public improvements, and planning for the future. Equally longlived and equally important will be his example and inspiration to his associates in public service. He taught people to be ashamed of compromise bought at the price of self-respect. He gave people courage to say unpleasant things that had to be said before more pleasant things could be accomplished. Among Santa Barbarans most active in public service he became a symbol of courage that is so costly to personal comfort and ease, and so necessary to welfare and progress.

Doctor Brown came to Santa Barbara in 1906 at the age of 28. He crowded a lot of living into the thirty-four

* Under the caption, "Dr. Rexwald Brown, Physician and Surgeon—and 'Warrior,'" the *Santa Barbara News-Press* of June 22, 1940, printed as its leading editorial the article which appears as an obituary in this issue of CALIFORNIA AND WESTERN MEDICINE. Doctor Brown, whose death occurred on June 21, 1940, was known throughout California as the founder of the Santa Barbara Clinic.

years that followed. Long before his age warranted it he was known to his friends as "Dear Old Rex." He attained the finer fruits of age—fair judgment, kindliness to the stupid and ignorant, and ability to accept delay without thinking of defeat—long before they come to most men.

For Doctor Brown his friends and his community can offer only one fitting tribute—the will to carry on.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN...Asst. Chairman on Publicity

In Memoriam

There is a shadow in our day. Since last we gathered, five of our members have gone to that other shore.

Shelley has said:

"They are not dead, death is but a low mist which cannot blot the brightness it may veil. They have but outsoared the shadow of our night. They are secure from the contagion of the world's slow stain. They are one with nature, their voices we may hear in the music of the wind, the sea and the night's sweet bird, their tears are in the falling rain. Their presence is felt and known in darkness and in light, from herb and stone their souls, like stars, are beacons from the abode where the Eternal are."

There is no death. No star is set but it rises to shine again in a brighter dawn.

We pay tribute to:

Alameda County: Mrs. Harry B. Torrey, July 22, 1939.

Orange County: Miss Rose Love Boyd (sister of Doctor Boyd), August 19, 1939.

Riverside County: Mrs. B. E. Garrison, August 23, 1939.

Monterey County: Mrs. A. A. Arehart, June, 1939.

San Joaquin County: Mrs. Dewey R. Powell, September 13, 1939.

MRS. E. ERIC LARSON.

Component County Auxiliaries*Alameda County*

The final meeting of the season for the Alameda County Auxiliary was held on May 17 at the Claremont Country Club. The mothers of physicians and members were honored. Hostesses for the day were Mrs. Charles Dukes, Mrs. George Reinle, and Mrs. E. N. Ewer.

Following luncheon, Mrs. George Calvin, who concluded a happy and successful year as president, gave a report of the activities of the organization. The newly elected officers were installed, and Mrs. Ira Church assumed her new responsibilities as president. Mrs. F. J. Carlson reported on the convention at Coronado.

Mrs. Milton Shutes and Mrs. Roy Nelson arranged the program, which was contributed to by Jean Gray Hargrove, pianist; Mary Clyde Cortright, contralto; and Rose Bell, impersonator.

MRS. RENE VAN DE CARR, *Publicity Chairman.*

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 5867 Whitworth Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Von Hagen and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

Los Angeles County

The last regular session of the Woman's Auxiliary to the Los Angeles County Medical Association was held on Tuesday, May 28, at the Association headquarters, 1925 Wilshire Boulevard. This was a "Bring Your Husband" meeting, and we were honored to have a number of the doctors present at luncheon.

The program arranged for the occasion included an exhibition of the color film, *Arizona*, through the courtesy of the Union Oil Company.

Mrs. Arthur T. Newcomb presented the Dolores M. Barrow Memorial Library to the library of the Los Angeles County Medical Association.

The members of the Board and committee chairmen gave their annual reports. Officers for the coming year were installed. MRS. WILLIAM BENBOW THOMPSON.

*Marin County*

On the evening of May 23, the Marin Auxiliary held its last meeting of the fiscal year. It brought to a close a year unusually stimulating and interesting, due in a large measure to the personality of our president, Mrs. C. A. De Lancey. During her administration the attendance at meetings was high, and the annual bridge tea and Auxiliary play were most successful. It is with regret that we realize the year is over; but to most of us, looking back, it will stand out "like silver in the sun."

Our guest speaker was Mr. Nyles Christiansen of the American Red Cross, who told us of the work now being done by that organization in Poland, Holland, Belgium, and France.

Mrs. Harry O. Hund, President-Elect of the California Medical Auxiliary, gave us a résumé of the convention at Coronado.

The following officers for the coming year were unanimously elected: Mrs. Lloyd Tyler, president; Mrs. Harry Hensler, first vice-president; Mrs. John C. W. Taylor, second vice-president; Mrs. E. V. Knapp, secretary; Mrs. George Lowell, treasurer.



On Sunday, June 2, the Woman's Auxiliary to the Marin County Medical Society entertained their husbands at a barbecue, which took place at the summer home of Dr. and Mrs. Wilson Goddard on Bolinas Bay. On the committee for this last social event of the season were Mrs. Wilson Goddard, Mrs. Alfred Schwarz, Mrs. Alex Miller, and Mrs. John C. W. Taylor.

Mrs. Frank Lowe presented Mrs. C. A. De Lancey, the retiring president, with a gift from the members of the Auxiliary.

Following luncheon in the outdoor dining room, games were played. MRS. JOHN C. W. TAYLOR.

*San Diego County*

Forty-seven members of the Woman's Auxiliary to the San Diego County Medical Society met on May 14 at the University Club. Mrs. William Cooke, President, presided.

This was the last business meeting of the year, and all annual reports were read.

The guest speaker for the day was Dr. L. F. Conti, former doctor for the San Diego Zoo. The subject for his very instructive talk was *Medical Observations of Wild Animals and Birds*.

The following officers were elected for 1940-1941: Mrs. R. Emerson Bond, president; Mrs. E. H. Kelley, first vice-president; Mrs. Elmo Crabtree, second vice-president;

Mrs. James A. May, secretary; Mrs. E. H. Christopherson, treasurer; Mrs. W. M. Alberty and Mrs. Joseph Maguire, members-at-large.

MRS. J. J. O'HARA, *Secretary*.

*(Press Clippings Continued from Page 47)***W. S. Franklin, M. D., Congressional Candidate in Tenth California District**

Dr. Walter Scott Franklin will seek election as congressman from the tenth congressional district. Shortly before noon today, the last hour for filing nomination papers in the August primaries, his petitions will be filed in each of the five counties that make up the tenth district—Santa Barbara, San Luis Obispo, Ventura, Kern, and Tulare. He will run on both the Republican and the Democratic tickets.

The fact that Doctor Franklin ran far ahead of his ticket as candidate for lieutenant-governor in California's last gubernatorial election to a total of some 1,200,000 votes, and that he was most prominently mentioned as a candidate for governor when a recall election seemed certain, caused him to receive many requests to enter the congressional race. He delayed his final decision in the matter until the last minute. The circulation of his petitions was not begun until the last minute for filing was only a few hours away. . . .—*Santa Barbara News-Press*, June 22.

**Doctors of Medicine and Rhythm to Play**

"California Rhythm Doctors," that group of medicos who have a talent for music, announce their first annual party to be held at the Hotel Claremont on Wednesday evening, May 22, when Bay society is invited to hear them. The band, incidentally supposed to be the only doctors' swing band in the country, will alternate with the orchestra in playing both for the dinner and entertainment.

Guests of honor for the evening will be Dr. and Mrs. Charles A. Dukes and Dr. and Mrs. Robert Thayer. Doctor Dukes is the president of the California State Medical Association and Doctor Thayer president of the California State Dental Association. Together with Mrs. William Harold Oliver, Mrs. A. A. Alexander and Mrs. T. Leslie Brown, they will sponsor the dinner-dance.

Fifteen hundred invitations will be mailed for the party. The purpose of the event is to raise money for the treasury so that when the players fill engagements which are purely for pleasure of their friends the financial burden will not fall upon any one member. It is expected that this will cover the year's activities.

Some of the affairs at which the doctors have donated their services for charity and other events are the Children's Hospital benefit, the American Medical Convention, the dinner-dance for the Woman's Auxiliary of the San Francisco County Medical Society, and the doctors' and lawyers' banquet at the Athens Athletic Club.

The California Rhythm Doctors include Doctors Wirt Miller, Roberto Escamilla, Fred Fisher, Edward Greer, Charles Greenwood, Frank Helfrich, Forest L. Horner, Lloyd Kindall, Jefferson Larkey, Norman Leet, H. A. McPherson, C. Martin Mills, Lowell Peterson, Thomas Robinson, Henri Sheffo, Robert Taylor and Alfred Wollitz.—*Oakland Tribune*, May 12.

**California Women Extend Cancer Drive Another Month**

San Francisco.—Continuation of the membership campaign of the Women's Field Army of the American Society for the Control of Cancer through May was announced today by Mrs. Paul Alexander of Redwood City, California, commander of the organization.

The annual fund-raising campaign has just been completed.

"Education of the public in the curative possibilities of cancer, through increased membership, is the best way to prevent more deaths through cancer in the United States this year than probably will occur in the European war," Mrs. Alexander said.

Into Smaller Towns

The membership campaign will be emphasized in the smaller communities of California where the organization has not yet reached, according to Mrs. Alexander.

Chance for Service

Ordinary membership in the American Society for the Control of Cancer carries nominal dues, Mrs. Alexander pointed out, and provides a wonderful opportunity for service to humanity. "The best outlet for the thousands of pieces of informative literature we can distribute about cancer is through members," she said. "With one or more members in every community, we will have made great strides towards banishing one of the leading causes of untimely death in our nation."—*Riverside News*, April 30.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.

California Medical Association, Hotel Del Monte, Del Monte, California, May, 1941. (Exact date not decided.)

Western Section of the American Urological Association, Empress Hotel, Victoria, B. C., July 29-31, 1940. Dudley P. Fagerstrom, M. D., Secretary, 710 Medico-Dental Building, San Jose, California.

Medical Broadcasts.*

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KTMS	Santa Barbara
KFSD	San Diego	KEX	Portland
KGO	San Francisco	KJR	Seattle
	KGA	Spokane	

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Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of July is as follows:

Wednesday, July 3—KECA, 11:15 a. m., *The Road of Health*.
Saturday, July 6—KFI, 9:45 a. m., *The Road of Health*;
KFAC, 10:15 a. m., *Your Doctor and You*.

Wednesday, July 10—KECA, 11:15 a. m., *The Road of Health*.

Saturday, July 13—KFI, 9:45 a. m., *The Road of Health*;
KFAC, 10:15 a. m., *Your Doctor and You*.

Wednesday, July 17—KECA, 11:15 a. m., *The Road of Health*.

Saturday, July 20—KFI, 9:45 a. m., *The Road of Health*;
KFAC, 10:15 a. m., *Your Doctor and You*.

Wednesday, July 24—KECA, 11:15 a. m., *The Road of Health*.

Saturday, July 27—KFI, 9:45 a. m., *The Road of Health*;
KFAC, 10:15 a. m., *Your Doctor and You*.

Wednesday, July 31—KECA, 11:15 a. m., *The Road of Health*.

Census Reports on United States Birth Rates.—The United States birth rate dipped slightly last year after rising in 1937 and 1938, according to preliminary tabulations of the Census Bureau, Department of Commerce.

A total of 2,262,726 births occurred last year, resulting in a birth rate of 17.4 births per each 1,000 estimated population. In 1938, the birth rate was 17.6, based on 2,286,962 births. The rate in 1937 was 17.0.

The preliminary 1939 rate is approximately 5 per cent higher than the lowest birth rate recorded in the history of the birth registration area established by the Census Bureau in 1915. The low point was in 1933, when the rate was 16.5. The rate for California in 1938 was 16.5; in 1939, was 16.8.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

University of California Courses to Help Teachers of Hard of Hearing.—Training courses for teachers of the hard of hearing and the deaf will be offered by the Los Angeles Summer Session of the University of California this year, with courses available in speech-reading, directed practice and conservation of speech and hearing, according to Dr. J. Harold Williams, dean of the session.

Information concerning all summer activities on the Los Angeles campus of the University may be secured on request of the Dean of the Summer Session, 405 Hilgard Avenue, Los Angeles.

Death Rates in the United States.—A slight rise in the United States death rate last year, as compared with 1938, is reported by the United States Bureau of the Census in a preliminary tabulation for 1939.

A total of 1,387,797 deaths last year resulted in a preliminary mortality rate of 10.7 deaths per 1,000 estimated population. In 1938, there were 1,381,391 deaths and the death rate was 10.6. The death rates for 1938 and 1939 were the lowest rates, with the exception of 1933, reported since the death registration area was established in 1900. California's death rate in 1938 was 12.4; in 1939, was 12.5.

American Red Cross: Summer Safety Is Subject of Dramatized Broadcasts.—In an effort to save thousands of lives and prevent tens of thousands of injuries during the next several months, the American Red Cross has arranged a series of eight dramatized radio programs on highway safety, prevention of drownings, and other mishaps. This summer safety series, which will be broadcast under the title of "Listen and Live," will be heard at 12 to 12:15 p. m., Eastern standard time, Sundays, from June 2 through July 21. Each of the programs will be closed with a brief talk by a nationally prominent guest.

The dramatized portion of each broadcast will be prepared under the direction of the First Aid, Life Saving and Accident Prevention Service of the American Red Cross. Each will graphically cover specific methods of avoiding accident and will emphasize what the hearer should do and what he should abstain from doing in case he runs into danger or meets with mishap, either to himself or others.

During the past thirty years this Red Cross service has given instruction in first aid to more than 2,000,000 persons and has taught more than 1,000,000 proper methods of rescuing persons in danger of drowning and reviving those apparently drowned. More recently it has been actively fostering farm and home safety by every possible means. From its extensive experience, vivid incidents will be drawn, incidents that will bring home to the hearer in a telling manner why the mishap in question occurred, how it and similar ones could be avoided and what might be done to relieve the situation. This safety series will be sent out over the Blue Network of the National Broadcasting Company, co-sponsor with the American Red Cross of this unique venture in humanitarianism.

Following is a list of California stations over which the series will be heard:

Blue Coast Group—KGO, San Francisco; KECA, Los Angeles; KTMS, Santa Barbara; KFSD, San Diego.

Medical Laboratory Technicians.—The California Association of Medical Laboratory Technicians announces that it is now composed of eleven county chapters, and that it has its own publication, "The Filter." Its next annual session will be held in San Francisco, September 28-29, 1940. The president of the organization is Mrs. Berenice Stevens, care of Merrit Hospital, Oakland.

Postgraduate Psychiatric Education.—The first regional institute of the American Psychiatric Association was held at Agnew State Hospital, Agnew, California, from June 17 to 29.

Participants in the institute at Agnew State Hospital were Dr. Charles A. Rymer, Assistant Director of the Colorado Psychopathic Hospital; Dr. Spafford Ackerly, Professor of Psychiatry of the University of Louisville, School of Medicine; Dr. Wendel Muncie, Associate Professor of Psychiatry of Johns Hopkins University Medical School; Dr. Walter Treadway, Assistant Surgeon-General, United States Public Health Service; and Dr. J. Kasanin, Chief of Psychiatric Service of Mount Zion Hospital, San Francisco.

Dinner in Honor of Dr. James F. Percy.—A dinner honoring Dr. James F. Percy was given by the French Hospital staff, Los Angeles, April 27, following twelve years of service as its chief and for his constructive work in the interest of the hospital. Doctor Percy was presented with an illuminated scroll, commemorating this service. Dr. Thomas C. Myers, President of the Board of Trustees of the Los Angeles County Medical Association, who presided, made the presentation address.

Doctor Percy was graduated from the Bellevue Hospital Medical College, New York City, in 1886. . . .

With the years in practice Doctor Percy has witnessed many worth-while events between the past and the present trends in medicine.

From February to April, 1888, he treated thirty-five children for diphtheria and signed thirty-five death certificates. Every physician in that city (forty-two in number) had a similar experience with his treatment of diphtheria patients—not a single child recovered. Diphtheria antitoxin did not become available for the treatment of the disease until 1894.

About this same time Dr. Ernest Hart, then the brilliant editor of the *British Medical Journal*, toured this country, lecturing to medical men that typhoid fever was a water-borne disease. In 1882, Doctor Percy saw in the old Bellevue Hospital, in the clinic of the then senior physician, Austin Flint, what was said to be the first demonstration of Koch's technique for staining tubercle bacilli. This was an extraordinary event and almost a spiritual experience for everyone who witnessed it. . . .

Among some of the recognitions that have come to honor Doctor Percy were the presidency of the Illinois State Medical Society, 1907; President Tristate (Illinois, Iowa, and Missouri) Medical Association, 1910; a founder member of the American College of Surgeons in 1913; a founder member of the Malignancy Board, Los Angeles County Hospital from 1922 until the present. This was among the first of these boards established in this country for the study and better care of the cancer patients. . . .

Many messages were received from colleagues over the country, among them Doctors Rock Sleyster, President of the American Medical Association; George H. Kress, Secretary of the California Medical Association; Malcolm T. MacEachern, Associate Director of the American College of Surgeons; Morris Fishbein, Editor of *The Journal of the American Medical Association*; Bowman Crowell of the American College of Surgeons; and others.

Examination for Appointment as Commissioned Officers in the Medical Corps of the U. S. Navy.—The next examination for doctors of medicine desiring to enter the Medical Corps of the United States Navy will be held on August 19, 1940, at the following Naval Medical Department activities (Pacific Coast):

U. S. Naval Hospital, San Diego, California; U. S. Naval Hospital, Mare Island, California; U. S. Naval Hospital, Puget Sound, Bremerton, Washington.

Information regarding physical requirements, etc., may be obtained by addressing a letter to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C. Applications must be completed and received in the Bureau of Medicine and Surgery prior to August 1, 1940, in order that authorization may reach the applicant in sufficient time for him to appear for examination on August 19, 1940.

University of California Medical School Offers Mail Library Service.—Establishment of a circulating periodical service for California physicians by the University of California Medical Center, was announced recently by Dr. Chauncey D. Leake, professor of pharmacology and librarian of the Medical School Library.

The University service replaces that previously provided by the State Medical Library. Volumes acquired by the State Library during the period of its operation, 1932-1939, are now on deposit at the University of California at Los Angeles and at the University of California Medical Center, San Francisco.

Rural physicians in California may now obtain books from the Medical Center Library and receive regularly any specialty journals in which they are interested. Service costs to meet mailing expenses are to be borne by the physicians, Doctor Leake said.

School of Nursing Established by State University.—A School of Nursing, replacing the present Training School for Nurses at the Medical Center in San Francisco, is announced by President Robert G. Sproul of the University of California. On July 1, all curricula in nursing and recommendations for degrees and certificates will be placed under the new school; the certificate in public health nursing is recommended by the department of hygiene.

The University, says President Sproul, for a long time has been endeavoring to raise the standards of preparation for nursing and to improve the quality of its instruction. At the close of the three-year course in the School of Nursing, the students will receive a Bachelor of Science degree and will be eligible to become registered nurses. In addition, there also will be offered curricula for graduate nurses leading to the Bachelor of Science degree and to Certificates in Public Health Nursing and Nursing Education.

Medical Center Won't Contract to Buy Bodies.—The University of California Medical Center will not enter into an agreement with any individual to purchase his body after death. This was announced by the Office of the Dean as a result of numerous offers reaching it in the past year. A spokesman for the Dean's Office said he knew of no reputable medical school or research institution in the United States which makes such contracts.

Although California law is not entirely clear on the subject, it is quite possible that a California citizen holds no property right in his body and, therefore, could not legally sell it, the statement said. Even if the law clearly allowed it, however, the Medical School would not enter into contracts to purchase bodies, nor will any other well-established research institution.

"We are deeply sympathetic with people whose dire financial difficulties make them contemplate this action," the Dean's Office announced. "But unfortunately it is not possible for us to help them in the way they desire."

The Pacific Coast Oto-Ophthalmological Society.—The twenty-eighth annual meeting of the Pacific Coast Oto-Ophthalmological Society was held Monday, June 24, to Thursday, June 27, inclusive, in Spokane, Washington, the Davenport Hotel being the headquarters. The guest speakers were Dr. F. K. Hansel of St. Louis, Dr. Walter B. Lancaster of Boston, and Dr. Meyer Weiner of St. Louis.

Highlights in California State Public Health Organization:

1850–1859:

Dr. Thomas M. Logan arrived in Sacramento to practice medicine. In 1856, together with Dr. E. S. Cooper, he issued call for organization of State Medical Society. Conducted correspondence with medical men and received reports of communicable diseases. As chairman of committee on medical topography of the American Medical Association (organized in 1856) wrote reports on such diseases. California Medical Society went into eclipse in 1860.

1860–1869:

Doctor Logan was practicing in Sacramento, writing on public health subjects for medical journals, active on Sacramento City Board of Health, of which he was secretary.

1870–1879:

State Board of Health established April 15, 1870, with Dr. Henry Gibbons, President, Dr. T. M. Logan, Secretary. Doctor Logan made president of the State Medical Society, reorganized in 1870.

In 1871, Logan, as chairman of committee of the American Medical Association on National Health Council, proposed a National Sanitary Bureau in Federal Government. A member of this committee was appointed from each state. Interest aroused in this proposal led directly to organization of American Public Health Association in 1873. Doctor Logan elected president of the American Medical Association in 1874.

Upon death of Doctor Logan in February, 1876, Dr. F. W. Hatch, Sr., appointed Secretary of State Board of Health.

1880–1889:

Doctor Hatch died in 1884, succeeded by Dr. Gerard G. Tyrrell, who was succeeded in 1891 by Dr. J. R. Laine.

1890–1899:

Doctor Laine succeeded in 1898 by Dr. W. P. Matthews. Rabies first appeared in California in 1899.

1900–1909:

Plague first appeared in United States in 1900, in San Francisco.

1902 Dr. N. K. Foster appointed secretary of the Board.

1905 Bureau of Vital Statistics established by law.

1905 Hygienic Laboratory established.

1907 Bureau of Foods and Drugs established.

1909 Mosquito and malaria surveys started and local control instituted.

1909 Doctor Foster resigned.

1910–1919:

1910 Dr. William F. Snow appointed secretary of the Board.

1911 State Tuberculosis Commission appointed, Dr. George H. Kress, Chairman.

1913 Morbidity reporting began on state-wide basis.

1913 Sanitary inspections by State inaugurated.

1915 Dr. W. A. Sawyer appointed secretary.

1915 Bureau of Tuberculosis established.

1915 Bureau of Sanitary Engineering established.

1917 Bureau of Venereal Diseases established.

1917 Dr. W. H. Kellogg appointed secretary.

1918 Influenza pandemic.

1919 Bureau of Child Hygiene established.

1919 Bubonic plague in Oakland.

1920–1929:

1920 Dr. W. M. Dickie appointed secretary.

1922 Bureau of Epidemiology established.

1922 Botulism from California commercially packed products.

1924–25 Plague in Los Angeles.

1925 Bureau of Cannery Inspection established.

1927 Crippled Child Act passed.

1929 State Department of Public Health established under reorganization of state government.

Tenth Meeting of the Biological Photographic Association.—The tenth annual convention of the Biological Photographic Association will be held at the Hotel Schroeder, Milwaukee, Wisconsin, September 12, 13, and 14. This society is interested in the further study of photography as applied to the biologic sciences, and the improvement of its technique. Scientific photographers from all parts of the country will meet to exchange ideas and information on still and motion picture photography as well as the latest developments in color work.

The membership of the Biological Photographic Association is composed of professional clinical and biologic photographers as well as physicians, dentists, and scientists who are interested in this specialized branch of photography.

In view of the growing interest in medical and biologic photography the next annual meeting promises to be especially stimulating and successful. Anyone interested in this subject is welcome to attend the meetings and to submit prints for the salon.

Further information concerning the convention program, salon specifications, and membership in the society may be had by writing to the Secretary of the Biological Photographic Association, University Office, Magee Hospital, Pittsburgh, Pennsylvania.

Civil Service Commission to Fill Medical Officer Position.—The United States Civil Service Commission has announced an open competitive examination to fill the position of chief of the medical division of the Civil Service Commission. Should vacancies occur in positions requiring similar qualifications in other Government agencies, they may also be filled from this examination. The salary of the position is \$6,500 a year, less a retirement deduction of 3½ per cent.

Because of the urgent need for filling the position, the examination will be open for a two-week period only. Applications must be filed with the Commission's Washington office not later than July 8 if received from states east of Colorado, and not later than July 11, 1940, if received from Colorado and states westward.

Applicants must have been graduated with an M.D. degree from a medical school of recognized standing; or must be licentiates of the National Board of Medical Examiners. In addition they must have had certain highly responsible professional experience in the field of medicine, partly in a managerial or supervisory capacity. Applicants obtaining the highest ratings may also be requested to appear for an oral examination.

Full information regarding the examination, and the application form, may be obtained from the Secretary, Board of United States Civil Service Examiners at any first- or second-class post office, or from the Civil Service Commission, Washington, D. C.

American Congress of Physical Therapy.—The nineteenth annual scientific and clinical session of the American Congress of Physical Therapy will be held on September 2 to 6, inclusive, at Hotel Statler, Cleveland, Ohio. This year there will be a departure from the usual arrangements in that the mornings will be devoted to an instructional seminar with the scientific program presented afternoons and evenings. This enables physicians to economize on time by attending both the instruction course and the annual convention during the same week. The entire instruction schedule is elective in character. Registrants may pursue only the individual courses they desire. The complete course consists of twelve lectures from a diversified list of forty-eight. The scientific program itself consists of papers, demonstrations, and motion pictures, covering every branch of physical therapy. There will be a separate scientific program, covering eye, ear, nose, and throat subjects. Write for schedule, fees, etc., to the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Film: "Choose to Live."—Officers of the Federal Security Agency and other governmental departments, and officials of District of Columbia governmental and voluntary health and welfare agencies were recently invited to preview a new documentary sound film, "Choose to Live," produced by the United States Public Health Service and the American Society for the Control of Cancer to aid in the campaign against cancer.

Preview screenings were held on Wednesday morning, April 17, in the auditorium of the United States Public Health Service, Nineteenth Street and Constitution Avenue, at 11:30 o'clock, and at Wilson Hall, National Institute of Health, Bethesda, Maryland, at 3:30 o'clock on Thursday afternoon, April 18.

Specially prepared for lay audiences, the picture tells the story of one woman's encounter with cancer and presents a background of educational information on the subject.

"Choose to Live" has been produced by skilled technicians. The actors in it are professionals, the laboratory and hospital scenes were taken with scrupulous attention to medical accuracy at Memorial Hospital, New York, Marine Hospital, Baltimore, and the National Cancer Institute, Bethesda, Maryland. The music score by members of the NBC symphony orchestra is an original arrangement by James C. Bradford. The musical background, the moving narrative, the human story, and the documentary pictures in hospitals and laboratories combine to give the picture unusual interest.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

**Medical Profession Plans to Push Fight
Determined Against Submitting to Federal Control of
Medicine**

New York, June 10 (AP).—American physicians today renewed their opposition to Federally controlled medicine and at the same time offered their complete coöperation to the government in the event of a war emergency.

In addresses before the house of delegates of the American Medical Association at the opening meeting of the annual convention the principal officers of the organization declared on one hand that the members were willing to devote their entire efforts to wartime service if necessary and on the other that they will not submit to peacetime control of private medical services.

Readiness Told

In a resolution presented before the opening meeting, the doctors declared in effect that "M" day—mobilization day for the armed forces—would also be "medical day" for the doctors of the country because they were already prepared to take care of the medical needs of both the Army and the civilian population.

Immediately after the resolution was introduced—approval was certain—Colonel George C. Dunham of Wash-

ington, assistant to the United States Army Surgeon-General, presented a resolution asking the coöperation of the association and its State and local societies in organizing a medical "column" prepared to heal the wounds and diseases of war.

Shortly before these actions, Dr. Arthur W. Booth, chairman of the board, reported that officials of the association, the District of Columbia Medical Society, the Harris County (Texas) Medical Society and the Washington (D. C.) Academy of Medicine would plead innocent before the District Court of the District of Columbia Friday to charges of conspiracy to violate the Sherman antitrust law.

At least five of the physicians present at today's meeting are under indictment in the case.

Dr. Nathan B. Van Etten of New York, incoming president, added the association "stands ready to coöperate to the limit of its ability in all measures of national defense."

Dangers Cited

He added, however, that while "love of country is a noble passion," it is necessary that medical men preserve "our patriotic ideals for the health and happiness of our people." It is necessary, even while engaged in a national emergency, to not "lose sight of the dangers to medical practice through concentrations of Federal authority" in regulating the practice of medicine.

Dr. Van Etten declared he approved the proposal of President Roosevelt to spend \$10,000,000 in the establishment of fifty small hospitals in needy areas throughout the country "where the need for them can be proved."

Need of Today

The need today, he said, is for "clean, warm places for the care of the acutely sick by competent personnel," workshops for adequately trained physicians and enough ambulances to carry chronically ill patients to large medical centers.—Los Angeles Times, June 10.

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Olson Ousts Dickie, Los Angeles Doctor Gets Job

After sixteen years' service as State Director of Public Health under five governors, Dr. Walter M. Dickie was ousted from the post yesterday by Governor Olson, who appointed Dr. Bertram P. Brown, Hollywood physician, to succeed him.

Some months ago the governor indicated that he intended to replace Dickie, whose reputation as a health officer is nationwide. This drew the fire of Dr. Howard Morrow of San Francisco, who declared that the California Medical Association strongly favored the retention of Doctor Dickie.

Doctor Brown came to this city in 1920 to establish practice. He is a native of Pennsylvania, where he was born in 1892.—Los Angeles Examiner, May 28.

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Doctor Bennett to Build Morale

Takes Over Post as General Hospital Director

Dr. Edwin S. Bennett, medical director for the last four and one-half years of the county's Olive View Tuberculosis Sanitarium at San Fernando, today took over his new job of superintendent of Los Angeles County General Hospital, declaring he was ready to assume immediately full responsibility for the institution's operation.

He said he was "convinced there is no basic trouble at General Hospital," the massive \$16,000,000 institution whose management has been the center of stormy controversy for many months.

To Build Morale

"The problem has been, as I see it," he said, "a lack of coördination and employee morale. I think that it can be corrected by giving the employees realization that someone will be there who is ready to take all responsibility for the hospital's administration.

"There will be mistakes, naturally, but I hope they will be few. I have no preconceived ideas on what my general administrative policy will be."

Doctor Bennett was appointed to the \$9,000-a-year post at the head of the largest acute disease hospital in the world by Rex Thomson, county superintendent of charities.

Doctor Bennett's new post recently was created by the Board of Supervisors to replace that of executive director, from which Everett J. Gray was retired by the board six months ago amid charges of "turmoil" at the institution and complaints about administration.—Los Angeles Evening Herald, June 6.

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Doctors Appointed to State Posts

Angeleno and Monrovia Named to Health Board

Governor Olson yesterday appointed two to the State Board of Health, Dr. Francis Marion Pottenger of Monrovia and Dr. Elmer Belt of Los Angeles. . . .—Los Angeles Times, June 22.

New Health Set-up Sought for City of Los Angeles
Reorganization of City Department to Include County
Urged in Report

Reorganization of the City Health Department as a metropolitan health district to include Los Angeles and adjacent territory under a five-year plan looking to better service and efficiency is recommended as the result of an exhaustive survey for the Board of Health commissioners.

A digest of the committee's findings released yesterday by Director Walter M. Dickie of the State Health Department added that the "ideal" solution of the matter would be to have such a metropolitan health district embrace all city and unincorporated territory in Los Angeles County.

Hampers Enforcement

"The question of territorial jurisdiction involves practically every public health activity in the metropolitan area and makes sanitation of foods and beverages, enforcement of effective quarantine and so on difficult of adequate supervision by any one of the present health agencies," the survey commented.

"Not only would more effective public health be secured under a metropolitan health district plan, but duplication of administrative overhead expense and duplication of considerable field work and expense would be eliminated at a substantial saving in such as present multiple expenditures."

Committee Proposal

The committee, headed by Dr. F. A. Carmelia of the United States Public Health Service, recommends that such a district be set up with a central administration, a bureau of preventable diseases and a bureau of sanitation.

Under the director, who should receive from \$8,000 to \$10,000 a year, the committee set forth, there should be organized a section of accounting and one of personnel. And since Dr. George Parrish, present head of the City Health Department, will be retired in about two years for age and must be replaced, an assistant director should be appointed as soon as possible, the report set forth.

Program for Bureaus

The Bureau of Preventable Diseases should consist of eight sections: general statistics, control of acute communicable diseases, control of tuberculosis, control of venereal disease, industrial hygiene, maternal and child hygiene, public health nursing, public health laboratory, the committee urged.

The proposed Bureau of Sanitation would embrace a division of food sanitation, a division of environmental sanitation and miscellaneous services division.

Urge Budget Increase

Under the five-year plan the first step would be to increase the present city Health Department budget from the current \$700,000 at a rate of 20 to 25 per cent annually, or from \$140,000 to \$175,000, for five years.

"The second, third, fourth and fifth years should be devoted to giving effect to such detailed plans as will be developed and which will require considerable subordinate personnel, office and clinic facilities, equipment and so on. . . ."

"The reorganization plan also proposes the establishment for the present of at least eight district health centers. It contemplates that each of these health centers should, within its district, constitute a functional replica in limited degree of all the appropriate functions of the city Health Department itself."

Coördinator Urged

The work of the various health centers would be supervised and coördinated by the assistant director, the report added.

Dr. John C. Ruddock, president of the Board of Health Commissioners, and Doctor Parrish, city health officer, withheld comment until they have seen the report which they said had not arrived at their offices yesterday."

The Health Commission will conduct a regular meeting today, at which the survey report may or may not be discussed, Doctor Ruddock said.—*Los Angeles Times*, April 30.

Medical Post in SRA Filled

Appointment Goes to Dr. K. C. Gummess of Los Angeles

Appointment of Dr. K. Chester Gummess, Los Angeles physician, as medical director for the State Relief Administration, was announced yesterday by Walter Chambers, SRA Administrator.

Doctor Gummess succeeds Dr. A. E. Larsen, who recently resigned to accept the position of medical director for the Agricultural Workers Health and Medical Association.

He will take charge of the SRA medical program tomorrow, with offices at 155 W. Washington Boulevard.—*Los Angeles Times*, June 9.

Dr. F. B. Young Named on Board of Health

Sacramento, June 4 (UP).—Governor Olson appointed Dr. Frank B. Young, a surgeon of Long Beach, to succeed Dr. Roy Terry, also of Long Beach, as a member of the State Board of Public Health. Doctor Young will serve until January 15, 1944.—*San Francisco Chronicle*, June 5.

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\$300,000 Health Service Building for U. C. L. A.

Designing of a \$300,000 Student Health Service building for the University of California at Los Angeles campus will begin immediately, it was announced today by Provost Earle Raymond Hedrick.

Allison and Allison have been appointed architects for the new building, which will be the twelfth on the campus. The same firm designed six of the present group.

The projected plan will provide a complete health service for students, exclusive of hospitalization, it was announced.

President Sproul recently outlined the need for an expanded health service, pointing out that at present the limited health service available to a student body of about 8,500 is crowded into inadequate quarters.

The health program will combine men's and women's services under one roof, increase the regular staff of attendants, expand the scope of services offered, and provide additional instruments and equipment, according to the plans.—*Los Angeles Herald and Express*, June 22.

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Health Plan Scored

Dentists Against Insurance

Portland (Oregon), June 22 (INS).—The nation's 45,000 dentists are unalterably opposed to compulsory health insurance, Dr. Wilfred H. Robinson, Oakland, President-Elect of the American Dental Association, was on record today as advising delegates to the Oregon Dental Association convention.

He said the National Association approved setting up voluntary health insurance systems, however.—*San Francisco Examiner*, June 23.

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New General Hospital Head Urges Advisory Board Revision

Recommendations that the Medical Advisory Board of Los Angeles County General Hospital be reduced from seventeen members to ten, each member serving one year instead of five, were filed yesterday with the Board of Supervisors by Dr. Edwin S. Bennett, newly appointed superintendent of the institution.

Doctor Bennett also is of the opinion that one of the members of the Advisory Board should be the Health Officer of the city of Los Angeles. At present only the County Health Officer serves.

He also asks the Supervisors to include the following as members:

Chairman of the hospital staff, who shall act as chairman of the Medical Advisory Board; chief of the medical service and chief of the surgical staff of General Hospital; dean of the School of Medicine, University of Southern California; president of the College of Medical Evangelists; president of the Los Angeles County Medical Association; secretary of the Los Angeles County Medical Association; chief of all curative clinics under the San Fernando Plan; Health Officer of Los Angeles County; Health Officer of the city of Los Angeles.

This would drop from the present personnel of the advisory board the executive superintendent and medical director of the hospital; assistant medical director; superintendent and medical director of the Rancho Los Amigos, executive superintendent and medical director of the Olive View Sanatorium.—*Los Angeles Times*, June 21.

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Wilbur Hits Compulsory Health Plan

San Diego, May 12 (AP).—Dr. Lyman Wilbur, Stanford University president, assailed proposals for compulsory health insurance legislation by federal or state governments in a nationwide broadcast from Paradise Valley Sanitarium at nearby National City.

"We do not know enough about really workable methods," declared the former Secretary of the Interior in the Hoover Cabinet, "to crystallize into legislation regulations for providing health and medical care for everybody."—*San Francisco Examiner*, May 13.

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Health Plan Extension Is Okehed by Physicians

Coronado, May 8 (AP).—The California Physicians' Service has approved a plan to extend its voluntary health insurance facilities to students of the sixty-three colleges and junior colleges in the State. The plan now goes to the House of Delegates of the California Medical Association, in convention here, for final sanction.

A request that the service be made available to individual members to permit farmers in agricultural sections of the State to join was rejected, a spokesman for the group reported.

Dr. C. Kelly Canelo, San Jose, and Manager Thomas J. O'Dwyer, Los Angeles, were reelected C. P. S. trustees. The interim appointment to the board of Dr. Dewey Powell, Stockton, was approved.

The resignations of Dr. Lowell Goin, Los Angeles, and Dr. Earl Mitchell, Oakland, were accepted. Dr. Morton R. Gibbons Sr., San Francisco, was elected to the board, and the board's membership was increased from nine to eleven.

Dr. Edward H. Rynearson of the Mayo Clinic told delegates to the Association today that people who say, "I get fat even if I don't eat a thing," are taking liberties with the truth.

"The cold, hard fact is that the only source of fat is food," the Mayo physician said. "It is true that individuals are preordained to follow a certain type of bodily architecture. But even the fattest person can reduce safely if the amount of calories is properly restricted under supervision of a competent physician."

Doctor Rynearson said there was no "safe short cut" in reducing. "Much serious damage can be done by the indiscriminate following of 'fad' diets. Even greater damage results from attempts to lose weight from the unwise use of drugs and hormones."

Moderation in eating was urged by the physician, who said insurance statistics agreed that obese individuals die younger and are much more subject to disease than persons whose weight is normal.—*Modesto Bee and News-Herald*, May 8.

* * *

Remove Mystery Air, Urges L. A. Doctor

The medical profession in California would come out from behind the screen of mystery which hides it from the layman's view if a resolution proposed yesterday by Dr. Paul A. Quaintance, Los Angeles, is adopted.

Doctor Quaintance at the Coronado convention proposed that "the Association countenance submission by members for publication articles on medical topics written in language designed for instructing the people." He urged that county medical societies create public relations committees to review and approve such articles.

He pointed out that "adequately subsidized minorities are utilizing press and radio to spread propaganda tending to impair the confidence of the public in the medical profession and to foster demands for radical changes in the system of medical practice. Organized medicine, he said, has not utilized sufficiently the means available for public health education."—*San Diego Union*, May 8.

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State Medical Group Sanctions "Hospital Care for All" Plans

Task Delegated to California Physicians' Service Through Its Health Insurance Program

Coronado, May 9 (AP).—A program designed ultimately to assure adequate medical and hospital care for everyone received the sanction of the California Medical Association, which adjourned its sixty-ninth annual meeting today.

The Association delegated the task to the California Physicians' Service through the latter's eight-months-old prepayment health insurance plan.

Heading the list of C. P. S. extensions authorized is a proposal to make the service available on a clinical basis to the estimated 350,000 persons dependent on state relief. The undertaking would require a legislative appropriation, and probably will be presented to the special legislative session next week.

Aid for Students

Also approved is a plan to extend the service to college and junior college students, subject to agreement by the county medical societies in which the institutions are located.

Indicating further liberalization of the plan, the Association named a committee to formulate plans to effect a downward rate revision to make the health and hospital service to the low-income group receiving \$100 or less a month.

The plan, now subscribed to by 12,000 persons, is available to groups of five or more having annual individual incomes of not more than \$3,000. Alson Kilgore, San Francisco, C. P. S. secretary, urging the revision, said the \$2.50-a-month charge is prohibitive to the low-income group.

Proposal Tabled

Pending further growth of the C. P. S., the Association tabled a proposal to extend the service to individuals, a suggestion offered to permit participation particularly by farmers in the San Joaquin Valley and other agricultural sections.

Although the drive against any compulsory medical plan will be waged chiefly through the C. P. S., the Association authorized action through other avenues to bolster the profession's hold on the management of the economic factors of medicine.

The Association referred to its Council for study a resolution of John H. Shephard, San Jose, to provide a comprehensive subsidization for any patient who chooses to go to a private hospital. . . .—*Los Angeles Times*, May 10.

* * *

Fight on "Political" Medical Service Urged

Coronado, May 6 (AP).—Dr. W. H. Bueermann of Portland, Ore., urged the medical profession itself to answer demands of "pressure groups" for "politicalized medicine" which he said would be administered by an "unsympathetic and nonmedical bureaucracy."

Speaking before the opening convention session of the California Medical Association, the Portland physician gave an account of seven years of operation of the Multnomah Medical Service Bureau of Portland, which he heads.

Doctor Bueermann said there had been increasing evidence the last ten years that provision should be made for medical care of low-wage industrial workers on a voluntary payment basis.

"The medical profession has decreed that the solution must be met through its own leadership, and that the medical care of the worker can best be solved by developing feasible plans of voluntary health insurance which meet the existing needs."

Doctor Bueermann's address brought out the similarity of conduct of the Portland bureau with the California Physicians' Service, which was organized last year for persons in low income brackets. The maximum limit for patient membership in Portland is \$1,800, differing from the California set-up in which the upper limit is \$3,000.

During its operation, Doctor Bueermann said, the bureau had received annual income increases from \$4,157 in 1933 to an estimated \$333,227 in 1940. Fees to physicians for the same period range from \$146,000 to \$185,000, the latter estimated for this year.—*Long Beach Press-Telegram*, May 6.

(Press Clippings are Continued on Page 41)

LETTERS

Subject: Guest Speaker Rynearson's Opinion of the Coronado Annual Session.

(COPY)

MAYO CLINIC

Rochester, Minnesota,

May 27, 1940.

Dr. George H. Kress

Secretary, California Medical Association

450 Sutter, San Francisco, California

Dear Doctor Kress:

. . . I just want to send you this personal note to congratulate you, as the secretary, for the splendid job which you did. I have attended quite a few state meetings and I have never in my life seen anything to compare with the splendid arrangements which you had perfected at Coronado.

Mrs. Rynearson joins me in thanking you for your many acts of kindness.

Very truly yours,

E. H. RYNEARSON, M. D.

Subject: Reaction of the Public to the Graduating Class of the University of Southern California Medical School.

(COPY)

Los Angeles, June 13, 1940.

Dear Doctor Kress:

At the Commencement Exercises of the University of Southern California in Los Angeles, there was a surprising occurrence in which I thought you might have an interest.

They were introducing, by groups, the candidates for degrees. The arrival of the President of the University of Southern California and his party received the appropriate handclapping. The introduction of those for honorary degrees received similar recognition. The doctors of philosophy received the same. When the Dean of the Medical School asked that the candidates for the Degree of Medicine rise, there was a spontaneous roar of applause that was almost startling. With probably about fifteen thousand spectators in the stadium, it was as though a famous athlete was about to enter the game or as though a close game had just been decided by a touchdown. The applause was so remarkable that even the members of the class turned to see what had happened. As a member of the audience, I thought for a moment something that I had not seen was going on. The young graduates, in a talk with them after the exercises were over, were quite astounded by the ovation.

I have no explanation for this other than the thought that the public at this time of war stress is more appreciative of such types of trained men. Maybe there has been a distinct turn in the trend of public opinion in our community. Would it not be interesting to learn whether similar such phenomena occurred in other similar exercises in this State. It was so in contrast to other such occasions which I have attended here that I thought it worthy of bringing it to your attention.

Fraternally yours,
H. W. SPIERS, M. D.

✓ ✓ ✓

(COPY)

UNIVERSITY OF CALIFORNIA

Medical School, The Medical Center
June 20, 1940.

To the Editor:—Thanks a lot for your note of June 17, giving me the opportunity to read Doctor Spiers' letter of June 13 regarding the applause at the Commencement Exercises of the University of Southern California when the medical graduates came forward to receive their degrees. For several years we have noted the tendency toward the same sort of enthusiastic response at the University of California Commencement Exercises in Berkeley. I think it reflects a bit the appreciation of the public of the physicians' unselfish devotion to human welfare and the ideals of the medical profession in holding human welfare above the more personal selfish interests of the doctor himself. . . .

Faithfully yours,
CHAUNCEY D. LEAKE.

Subject: A Proposed "Non-Medical Practice" Act for California.

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF
PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS

San Francisco, California,
June 18, 1940.

Re: Non-Medical Practice Act

To the Editor:—We were recently informed that Dr. J. Theo. Hollie, Chairman of the California Natural Healing Arts Association, 638 West Fortieth Place, Los Angeles, had requested the Attorney-General to prepare a title for an amended draft of a proposed initiative measure, designated "Non-Medical Practice Act."

The title as submitted by the Attorney-General is as follows:

"Non-Medical Healing Arts. Initiative. Creates Board of Non-Medical Examiners with jurisdiction over prac-

tioners of, and schools teaching, massage, physiotherapy, herbology, naturopathy, minor surgery, and obstetrics as defined in Act. Prescribes Board's qualifications, powers, duties, and compensation. Exempts employees from civil service. Requires examination of applicants; prescribes educational and other qualifications of licentiates, grounds for issuance and revocation of licenses. Accords licentiates all rights and privileges granted physicians, without discrimination, including access to all institutions supported by public funds. Requires State officials accept reports and certificates filed by licentiates. Defines unlawful practice, specifying penalties and disposition of moneys received from violations."

The Attorney-General is reported to have advised that the circulation title and summary prepared for a similar measure on December 14, 1939, is to be disregarded.

The above for whatever interest may be attached.

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

Subject: Medical Defense Brochure of the California Medical Association.

(COPY)

SALMONS AND WOLCOTT Co.*

San Diego, California,
June 14, 1940.

Dr. George H. Kress
Secretary, California Medical Association
450 Sutter Street
San Francisco, California
Dear Doctor Kress:

We thank you very much for the three copies of the Medical Defense Brochure. We think it is wonderful, and we enclose a copy of the letter we are sending Dr. F. E. Toomey, Secretary of the Medical Advisory Committee of the San Diego County Medical Society, concerning same.

You may be interested in reading some of the letters that we have sent out to the San Diego County Medical Society members from time to time, as they bring out some of the same thoughts.

Several years ago we gave the information here regarding the so-called New Haven Plan, and since then we have continued to do whatever we could on preventive work. We are glad to report that we are securing better cooperation and results.

San Diego Trust and Savings Building.

Very truly yours,

SALMONS AND WOLCOTT Co.
(Signed) Paul Wolcott.

✓ ✓ ✓

(COPY)

June 14, 1940.

Re: Malpractice Insurance

Dear Doctor Toomey:

We have just been privileged to read the Brochure on Medical Defense compiled by the Committee on Public Relations of the California Medical Association.

If all of your members have not yet received their copies, we assume they will shortly, and our thought in writing you is for you through the Bulletin, or whatever means possible, to impress upon your members the importance of most carefully reading this Brochure. It is marvelous, in our opinion, and most instructive, and should be re-read from time to time. It seems to us to be most beneficial for all members to make it a practice to read this every month.

Very truly yours,

SALMONS AND WOLCOTT Co.

* This firm has been handling the blanket medical defense coverage for the San Diego County Medical Society.

Subject: Equipment for Medical Personnel of Armed Forces of the United States.

San Francisco, June 18, 1940.

To the Editor:—When we finally go to war with those who oppose our way of living, medical units may find themselves wholly unprepared for modern warfare. Members of the medical profession who are interested in preparedness might find it wise to study Allied attempts at first-aid in Flanders and France. The fact is there simply hasn't been any possible. Unless hospital units are armored and mechanized along with other combat units, they will not be able to exist in modern warfare. It is no longer appropriate to leave these matters to the philanthropy of well-intentioned spinsters who like to give ambulances to the Red Cross. Modern military first-aid and hospital units must be fully armored and mechanized. This can only be accomplished through adequate national appropriations in connection with the streamlining of our armed forces. It would be wise for the medical profession to make sure that such provision for the Army Medical Corps is made.

CHAUNCEY D. LEAKE.

Subject: Personnel of United States Marine Corps.
(COPY)

UNITED STATES MARINE CORPS
HEADQUARTERS RECRUITING DISTRICT OF DETROIT
Detroit, Michigan,
June 3, 1940.

Dear Doctor:

The United States Marine Corps has been authorized by the Congress to increase its personnel by nine thousand men.

It will be the policy of this Recruiting District to fill its quota as rapidly as possible.

The enclosed blanks state the physical qualifications required of applicants for enlistment.

A high mental and physical standard of recruits has always obtained in the Marine Corps in the past, and it is planned to maintain that high standard during the present campaign.

The writer feels that a physician is ideally qualified, as a judge of human nature, as an expert in physical examination, and as an outstanding citizen in his community to select the type of man best fitted for the Marine Corps.

This is a time when all Americans feel that it is wise and urgent to put their shoulders to the wheel and aid the move for preparedness.

The writer earnestly solicits your aid in completing the important task, common to us all, of filling our armed ranks to their authorized limits with the finest men in America.

250 New Federal Building.

Very truly yours,

JOSEPH E. MALCOMSON,
Lieutenant-Commander, Marine Corps,
United States Navy.

Subject: Intravenous Drip Method for Treatment of Syphilis.

(COPY)

THE AMERICAN SOCIAL HYGIENE ASSOCIATION, INC.
New York, N. Y.

To the Editor:—The American Social Hygiene Association is interested in getting the following information to the medical profession and asks your coöperation in publishing this statement:

In order that there may be a central source of information with regard to studies of the intravenous drip method for treatment of syphilis ("the five-day treatment"), the American Social Hygiene Association at 50

West Fiftieth Street, New York, has been asked to gather and to keep available information regarding this subject. The Association requests all physicians and hospitals which are planning or are now carrying on studies of experiments with this method of treatment of syphilis to send brief information regarding the following points to the Association at the above address:

1. Name of hospital or other institution.
2. Name of principal physician in charge of the intravenous drip study.
3. Type of case or cases of syphilis treated by the intravenous drip method.
4. Name of drug or drugs used.
 - (a) By the intravenous drip method.
 - (b) By any other method before, during or after intravenous drip therapy. (Mention any specific therapy used.)
5. Routine laboratory work done on cases of syphilis treated by the intravenous drip method.
6. Usual number of hours of intravenous drip treatment per day per patient.
7. Usual number of days of intravenous drip treatment per patient.
8. Any other pertinent facts.

The Association will be glad, so far as possible, to answer inquiries regarding the intravenous drip treatment of syphilis. The Association has available to physicians, upon request, a brief pamphlet on the subject of the present status of the intravenous drip method of treatment of syphilis, written by Dr. Charles Walter Clarke, Executive Director of the Association and a member of the New York City Committee on the Intravenous Drip Treatment of Syphilis.

1 1 1

FIVE-DAY TREATMENT FOR SYPHILIS

The above headline, from page 1 of the *New York Times* of April 13, was typical of New York newspapers and other important journals throughout the country on that date. Almost without exception, front-page space, with striking headlines and several columns of text, was devoted to a report presented before a meeting of two hundred distinguished physicians on April 12 at Mount Sinai Hospital, New York, when the preliminary results of a new treatment method for syphilis were discussed. This new method may well be the most important advance in syphilis therapy since Ehrlich discovered salvarsan in 1910.

Developed by Dr. H. T. Hyman, Dr. Louis Chargin, and Dr. William Leifer, all of New York City, the method consists essentially in introducing very slowly into a vein an arsenical compound in high dilution of saline and glucose. The solution flows at the rate of twenty or thirty drops per minute for ten or twelve hours a day for a period of five days. The quantity of the arsenical which can safely be given in five days by this method is equivalent to the amount given in a period of three or four months by present standard methods.

About three hundred patients have now received this treatment with results which so far appear to be excellent. Infectious lesions have healed quickly and blood tests have become negative in a high percentage of cases. It should be understood, however, that experience with the five-day method is limited as yet to a single class of cases—early syphilis in men. It is not known whether the method can be applied to latent or late syphilis, or to syphilis in women (whether or not pregnant) or to congenital syphilis in infants and children. Experiment with such types of cases of course will be necessary. A good deal of time must necessarily elapse before the new treatment can be evaluated and before it can be available generally, should it prove satisfactory. Meantime standard methods of treatment are reliable and available almost everywhere.

Dr. Walter Clarke, American Social Hygiene Association Executive Director, and a member of the committee which supervised the treatment project at Mount Sinai Hospital, has prepared a statement which appears in the *May Journal of Social Hygiene* and to which *Social Hygiene News* readers are referred for further particulars. Address The American Social Hygiene Association, Inc., 50 West Fiftieth Street, New York, N. Y.

Ask for Publication A-272, *The Five-Day Treatment for Syphilis*—A brief popular exposition of the method and its present limitations, 5 cents.

50 West Fiftieth Street.

Subject: Governmental Publications on Venereal Disease.

(COPY)

FEDERAL SECURITY AGENCY
UNITED STATES PUBLIC HEALTH SERVICE
WASHINGTON

To the Editor:—*Venereal Disease Information* presents a monthly digest of the important papers on diagnosis, treatment, pathology, laboratory research, and public health from the entire world. In addition, it publishes important special papers and reports by leading scientists. It is designed to keep both the specialist and the general practitioner informed of developments in the field of syphilology and urology.

This medical journal of venereal disease has been highly recommended by leaders in all fields of public health. In a rapidly developing and changing field of medicine, the physician interested in venereal disease control from the standpoint of differential diagnosis and treatment will find *Venereal Disease Information* an important aid.

Venereal Disease Information is published monthly by the United States Public Health Service. Today it ranks as the Government's "best seller," with the highest paid circulation of any federal publication. It is available at 50 cents per year to all physicians.

New subscribers to *Venereal Disease Information* may receive, on request, any or all of the following supplements:

- No. 5—"Diagnosis of Syphilis by the General Practitioner" (1938)
- No. 6—"Management of Syphilis in General Practice" (1938)
- No. 7—"Syphilis in Mother and Child" (1940)
- No. 8—"The Gonococcus and Gonococcal Infections" (1939)
- No. 9—"The Serodiagnosis of Syphilis, Part II, Revised Technics" (1939)
- No. 10—"Control of the Venereal Diseases in the United States: Present and Future Plans" (1939)

All orders should be directed to the Superintendent of Documents, Government Printing Office, Washington, D. C. Subscription fee, 50 cents per year, in check or money order, *not stamps*.

Subject: Brochures on Gonorrhea and Syphilis.

(COPY)

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON

To the Editor:—Since the publication in September, 1939, of the first folder on gonorrhea in the present anti-syphilis disease campaign, it has become evident that, while many people still consider gonorrhea as "no worse than a bad cold," there is growing a wide interest in gonorrhea control.

Testimony to this fact lies in the distribution report on the new Public Health Service folder, "Gonorrhea the Crippler." It was released in September as the fourth folder in the "dollar-a-hundred" series,* and already more than 400,000 copies have been sold.

It is evident, however, that more complete information than can be encompassed in a folder is needed, and to assist those who are called upon to present to the public facts

about gonorrhea as a medical and as a public health problem, a booklet, "Twenty Questions on Gonorrhea," has been prepared.

"Twenty Questions on Gonorrhea" was developed with the active assistance of officers and members of the Neisserian Medical Society. It is written in layman's language for his use, and for the use of the physician who wants to know how to tell the story of gonorrhea in nontechnical terms. Every doctor should have a copy in his library for reference when he is asked to discuss gonorrhea control before lay audiences. And as a service to his patients every doctor should have a supply on his desk.

This new question-and-answer booklet, illustrated and with schematic anatomical drawings, is available from the Superintendent of Documents, Washington, D. C., for five cents a single copy, and with a 25 per cent reduction on orders of one hundred or more.

Sincerely yours,

R. A. VONDERLEHR,
Assistant Surgeon-General, Division
of Venereal Diseases.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

What May a Physician Expect of His Patient?

Nearly all of the articles written not only by the author, but by others, on the subject of medical jurisprudence deal with the responsibilities of a physician to his patient and the various phases of liability which may arise from failure to live up to all of them. For the purpose of throwing a little sunshine into the picture, this article will be devoted to an exposition of some of the duties which a patient owes to his physician.

In *Becker vs. Janinski*, 27 Abb. N. Carolina 45, a full statement of the patient's responsibility was set forth as follows:

All the obligation is not upon the physician, but the patient also has his duties to discharge. In particular, the patient must obey the orders and follow the directions of his physician, and if he disobeys such orders or neglects such directions, he cannot hold the physician for the consequences of such disobedience or neglect. Accordingly, I charge you that if you find that the injury of which the plaintiff complains was the effect of her carelessness or neglect alone or was the effect of the defendant's negligence or want of skill in combination and coöperation with her own carelessness and neglect she cannot recover. Her contributory negligence would defeat the action.

Most of the instances where objection is made to the conduct of the patient arise out of a failure on the patient's part to follow instructions. However, a patient not only has an obligation to follow reasonable instructions, but he is required continually to exercise such ordinary prudence as would be expected of a person in his position, and a failure on his part to exercise such prudence will prevent recovery.

In reference to the duty of a patient to follow instructions, various situations may arise.

Refusal to Submit to Treatment. A patient is bound to submit to the treatment prescribed by his physician or surgeon if it is such as a physician of ordinary skill would sanction, and a physician or surgeon who is prevented from

* No. 1, "Syphilis—Its Cause, Its Spread, Its Cure"; No. 2, "Syphilis and Your Town"; No. 3, "You Can End This Sorrow"; No. 5, "Gonorrhea the Crippler."

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

correcting an ailment by the refusal of the patient to submit to the proper treatment cannot be held liable for resulting damages. Where the patient is incompetent to speak for himself, and the members of his family refuse to permit an operation or other proper treatment, the physician is relieved from liability for the course pursued or other injuries resulting from failure to apply the treatment.

Failure to Return for Treatment. A patient who, after receiving treatment, fails to return to have the entire course of treatment completed, is guilty of contributory negligence. In other words, his own act has contributed to his injury. However, it should be stated that if the patient's failure to return is a result of his discovery that his condition is not improving because of the physician's negligent treatment, the patient may go to another physician for proper treatment and still hold the first liable for such injuries as had occurred prior to the change.

Generally speaking, negligence of the patient will bar any action based upon the negligence of the physician on the theory that the negligence of the patient supervenes that of the physician. However, it has been held that if both the physician and the patient have been negligent and the injuries due to the respective negligence of each can be separated, the physician is liable for the injuries due to his own want of skill or care. It has further been held that where the liability for negligence on the part of the physician has already been incurred, subsequent negligence of the patient which merely aggravates the injury does not discharge the physician from liability for such damage as would have occurred regardless of the patient's act.

Some cases have held that a physician may not be held liable for injuries resulting from an operation performed at the insistence of the patient despite the physician's advice that it is unnecessary and improper. Thus, it has been held that where the patient did not consult his surgeon as to the propriety of bleeding him, but only required the performance of the manual operation, there was no liability. However, a physician should always be wary of patients who have definite convictions as to what form of treatment they want. When actually faced with injury, such a person may state that the treatment itself was negligently performed or even take the position that he did not really give any directions, but that the act was done upon the suggestion of the physician and acquiesced in by the patient because of his reliance on the physician's superior knowledge. It is suggested that whenever a physician is asked to perform an act which is against the physician's best judgment, the patient should be sent elsewhere. At least a physician should obtain a written statement from the patient to the effect that he is receiving the treatment against the physician's advice.

Finally, there are instances in which a physician secures from a patient a writing in which an attempt is made to have the patient assume all risk. It must be remembered that even though such a writing is obtained and may have the effect of eliminating liability in so far as the choice of the method of treatment is concerned, nevertheless, a liability for negligent performance of the treatment will remain. A physician cannot eliminate by contract liability for his negligence. Thus, it has been held that where a patient was warned that danger attended the use of x-rays and the patient agreed to assume the risk, such assumption would not be deemed to cover the operator's negligence.

Generally, it may be said that the rules of contributory negligence are mere expositions of a rule of fairness. However, occasions may arise in which an act that appears fair and reasonable to the physician may not appear as such to a court or jury. For that reason, a physician should always keep in mind the general directions of the law in reference to the conduct which may be expected of the patient.

ENDOCRINOLOGY: A CRITICAL ANALYSIS*

By EDWARD H. RYNEARSON, M. D.

Rochester, Minnesota

Suggested Reading

THE PITUITARY

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(Continued in Front Advertising Section, Page 5)

* This paper is in two parts: Part I appeared in the June issue of CALIFORNIA and WESTERN MEDICINE (page 257); Part II appears in current issue (page 12).

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 7, July, 1915

From Some Editorial Notes:

Surgeon-General Rupert Blue, President-Elect of the American Medical Association.—It is an unusually keen pleasure to announce not alone that General Blue was elected President of the A. M. A., but that the election to that office occurred in San Francisco; and furthermore, that it was an expression of a spontaneous desire to have him at the head of the Association, and not in any way a matter of "medical politics." No more appropriate thing could have happened than for the office to come to him in the city for which he did so much; in the city in which his great idea was born, the idea that alone would mark any man as great—the idea accepted by the world as the ultimate solution of the problem of bubonic plague—building out the rats. The biggest part of Doctor Blue's work in California is not a part of the record; it will never go into official reports or be a part of any government document, but it showed him to be a master diplomat as well as a public health genius, and endeared him to the people of California and of San Francisco. His biggest problem in dealing with the plague situation in San Francisco was to harmonize the many warring elements and bring many men who were unfriendly to each other, into a state of mind wherein they would work for the common cause; and this he did so quietly, so perfectly and so thoroughly, that few people realized what was going on. . . .

The registered attendance at the San Francisco session was about 2,300.

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Physician's Rights.—Many questions are propounded to the Secretary in regard to the rights and duties of physicians and their relations to the public and to their patients. It is singular but nonetheless true, that not alone the lay public generally, but many physicians, seem to think that they are more or less in the nature of "public carriers"; innkeepers, etc.; that they must respond to a call or must treat a sick person if sent for to do so. This is not at all the case. Quite the contrary. Nor is this definite statement merely a matter of opinion as these points have been settled in court and the decision sustained. It does not matter whether the person sending for a physician is or is not able to pay him a proper compensation; nor does it matter what the circumstances are, the urgency of the call, inability to get another physician, etc. The courts have ruled in one case at least, that even when money was tendered, no other physician could be reached in time and the patient died as the result of a physician's flat refusal, without stated reason, to visit and treat or prescribe for this sick person, the physician was in no way liable and the suit against him was dismissed. Any physician may elect whether or not he will undertake to exercise his professional ability and accept the offered employment in any given case. No one and no law compel him to extend his professional services, either with or without compensation, unless he wishes to do so.

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Patient's Rights.—A physician having accepted a call to attend a sick or injured person is, however, a different case. His acceptance of the call and his treating the patient are taken by the courts to mean the undertaking of an implied contract based on ordinary reason and common justice. The physician, by accepting the call, indicates that

(Continued in Front Advertising Section, Page 25)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA †

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

News

"Dr. Lucius R. Wilson, superintendent of the John Seely Hospital in Galveston, yesterday was top man in the scramble for the post of director of the county's General Hospital. A rating of 105.16 put Doctor Wilson at the top of the list of four men certified for the post by the Civil Service Commission. . . . The other doctors certified by the Commission were Dr. Edwin S. Bennett, medical director at Olive View Sanitarium; Dr. Isidor H. Sheffer, medical superintendent of the Metropolitan Hospital, New York City, and Dr. Francis J. Bean, assistant superintendent of the University of Nebraska College of Medicine. Doctor Wilson and Doctor Bennett benefited by a 10 per cent addition to their grades because of the Civil Service ruling giving to former service men the differential in the markings. . . . Twenty-one doctors originally showed interest in the position but only seven took the test." (Los Angeles News, May 10, 1940.)

"In an effort to reduce the death toll from drugs heretofore purchased without restrictions, the State Board of Pharmacy yesterday adopted a resolution prohibiting the sale of dangerous sleeping potions unless prescribed by physicians. Since January 1, according to John A. Foley, secretary of the Board, there have been twenty-three deaths in Los Angeles and vicinity and seven in the San Francisco area, either through suicide or accident, as a result of promiscuous purchase of the deadly drugs. Drugs specifically listed by the Board include veronal, barbital, barbituric acid and several others. These hereafter may be sold at retail only on the written order or prescription of a physician and surgeon, osteopathic physician and surgeon, dentist or veterinary surgeon duly licensed to practice in California. . . ." (Los Angeles Times, May 17, 1940.)

Under date of May 25, 1940, the California State Board of Public Health "adopted under Section 205, Paragraph D, of Article 1, of the Health and Safety Code," a resolution naming veronal, barbital, acid diethylbarbituric, barbituric acid, or any of their salts, derivatives or compounds, phenobarbital, or any of its salts or compounds, acetylurea, sulfonated methanes, or any of their salts, derivatives or compounds, phenylhydantoin, or any of its salts, derivatives or compounds, as dangerously poisonous drugs, chemicals and medicinal substances, permitting their sale only by written order or on "prescription of a physician and surgeon, osteopathic physician and surgeon, dentist or veterinary surgeon, duly licensed to practice in the State of California," with a further order that such prescriptions "shall not be refilled without the written order of the prescriber."

"Thirty-seven druggists in Sacramento pledged themselves not to sell medicines for venereal diseases without a physician's prescription. . . . This was announced today by Glenn E. Coolidge, public relations officer of the department (of public health), who said persons who ask for medicines or advice for treatment will be referred to their family physicians or to the municipal clinic at Fifth and "I" streets. Druggists coöperating in the campaign are furnished with certificates for display in their stores. . . . The move to stamp out self-treatment of venereal diseases

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† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



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In supplying the profession with the Baxter TRANSFUSO-VAC and its accessories—the accepted new technique for blood transfusion—the same rigid standards as to quality, inspection and aseptic procedure at all times obtain. Like all other Baxter solutions, the Solution used in this technique—2½% Sodium Citrate in Physiological Solution of Sodium Chloride—is safeguarded by Baxter's 21-test, double-check system.

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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 30)

from the textbooks on operative surgery. Still, beginning and finishing an operation are both important phases of it, and placing an incision so as to have it convenient, adequate, as harmless as possible and likely to heal easily with but little deforming scar, is not an unimportant matter. Kocher's teachings regarding the relations incisions should have to the cleavage planes of the skin, segmented incisions, and finally his scheme of normal incisions are, of course, still fresh; and there has been but little added to what he said, but rather a constant regard for an application of his dictum about the sparing of nerve as the most highly differentiated tissue in the part, the one with the closest relation to the tissues in its distribution region, and the one that will be surely the slowest to repair if it repair at all. . . .

From an Original Article on "Pertussis," A Résumé of Our Present Knowledge, by W. W. Behlow, M. D., San Francisco.—Pertussis is an epidemic disease. It is more frequent and severe in cold climates but is otherwise not influenced by season and weather. Epidemics vary greatly in virulence, intensity, and mortality.

In the ordinary sense, pertussis is not air-borne, although it may be transmitted by droplet infection. It may spread by indirect contact or by third persons, but the usual method is from person to person as in diphtheria. Domestic animals are subject to the disease and are undoubtedly responsible for some of its transmission. Although not contagious during the periods of the disease even after convalescence, it is most contagious during the period following the appearance of the early symptoms. . . .

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From an Original Article on "The Urobilin Test in Malaria," by J. R. Snyder, M. D., Sacramento.—Plehn, in 1910, reported a study on urobilin and its significance in relation to malarial infection. Many Germans returning home after a stay in the East African Colony would apparently recover from their malarial fever and, later, especially after a return to the tropics, develop the disease. This work was the result of an endeavor to find some means of recognizing "latent malaria." In a case presenting chills and fever and plasmodia in the blood we have little trouble in making a diagnosis, but after 24 to 48 hours' administration of quinine the plasmodia disappear from the blood stream. Further, in malarial countries where a prophylactic dose of quinine is regularly administered it has been found that a certain proportion of the population develops a strain of the plasmodia unaffected by quinine. . . .

From "Society Reports," Fresno County.— . . . The papers of the evening were "The Remote Effects of Deflected Nasal Septum, With Some Operative Results of Submucous Resection," by Dr. Dewey R. Powell of Stockton and "Extra Ocular Palsies, With Report of a Case," by Dr. W. L. Benedict of Fresno. Both papers were carefully prepared and were of great value to the man in general practice. . . .

From "Address to Be Delivered Over the Body of a Young Man Dead of Typhoid Fever," by Assistant Surgeon General W. C. Rucker, United States Public Health Service, Washington, D. C.—We have met today for the sad purpose of performing the last solemn rites over the body of one who has passed into the Great Beyond. Our hearts

are overflowing with grief at the untimely ending of this life so full of promise. He had just begun his career. . . .

At any rate, the death of this young man could have been prevented! It was entirely unnecessary. It is the price which we are made to pay for somebody's ignorance and carelessness. The day is fast approaching when such sacrifices shall cease to be. It will arrive only when we have learned that the presence of typhoid in a community means that someone has been criminally negligent of his duty. Today, with hearts bowed down by the grief of our loss, let us resolve that we will henceforth so order our lives that we may conduct them without menace to others. Let us take unto ourselves the lesson of this hour, and in our own sorrow fix our determination to prevent the coming of sorrow to others. If we do this, this dead shall not have died in vain.

From "Medical Bills."—To the State JOURNAL: During the session of the forty-first Legislature, just completed, several bills of great interest to the practitioners of medicine in the State of California were brought up for consideration. In the discussion of these measures before the committees and upon the floor of the House and Senate, it was made quite evident that the chiropractors, mechanotherapists and others of that ilk had a great deal more influence than their numbers or medical importance would justify. This was due solely to the persistent campaign of speeches, letters and telegrams maintained by them and by their sympathizers. The Legislature had no desire to pass a vicious medical practice act. When hundreds of messages come in favoring and none opposing any bill, it is likely to be acted upon favorably. It is the intention of the chiro-

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

practitors to canvass the State before the next election in support of their bill which, as No. 46, was defeated in November, 1914. The apparent indifference toward all medical legislation shown by the representatives of the regular school and frequently remarked upon by our friends in the Legislature is largely due to lack of information. The rank and file of the county societies do not know what measures affecting medical practice are before the legislative bodies, what position their own representatives are taking and not infrequently, alas, who their Senator and Assemblymen are. The most time-consuming difficulty in the discussion of the medical laws has been the explaining to the legislators of the need for and requirements of a decent medical practice act. This difficulty could and should be attended to before they leave their own constituencies and come to Sacramento. On this account it has seemed advisable to the directors of this society to compile and transmit to the secretary of each county society a list of bills of special interest to medical men with a short résumé of each, and append thereto a list of the votes upon each measure in the Senate and the House. Thus the physicians of each community can, if they so desire, express by resolution or by letter their appreciation (or otherwise) of the acts of their own particular representative. . . .

Board of Directors, Sacramento Society for
Medical Improvement,
Per J. B. Harris, President.
F. F. Gundrum, Secretary.

The "going without breakfast" idea should be frowned on; for business men and women, the forenoon should be the most productive part of the day.—*Hygeia*.

BOARD OF MEDICAL EXAMINERS

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is endorsed by the United States Public Health Association, the Northern and Southern California Retail Drug-gists Association, the State Pharmaceutical Association and the State Board of Pharmacy and Medical Examiners." (Sacramento *Bee*, May 23, 1940.)

"Accused as the fake physician who robbed several aged San Jose men and listed as wanted for several similar thefts in other California cities, James Allen, 35, was held in jail in San Francisco today. Police here said Allen is charged with a series of local thefts, in which he posed as a physician sent by a welfare group or the county hospital, 'examined' his victims and robbed them of large sums of money. Latest crime of the sort charged to Allen locally is that in which August T. Gaimeraux, 80, of 125 Santa Teresa Street, was robbed of \$115 three weeks ago. . . . The (police) inspectors said Allen's system was to follow ill, blind or crippled persons about, visit them at their homes under pretext of being a physician . . . and depart with their money as he left, with the statement he would send back some medicine from drugstores. . . ." (San Jose *News*, May 11, 1940.) (Previous entry, June, 1940.)

"Cultists, whose shingles bear the title 'Dr.' without a further explanation of their true status, may soon find themselves in jail under a new West Virginia statute. Its sweeping provisions apply to 'any person' who uses 'the prefix Doctor or Dr. in any letter, business card, advertisement, sign or public display of any nature without affixing words designating the degree he holds.' Fines of from \$10 to

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Karo in Infant Diarrhea

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

\$500, plus a year's imprisonment, may be imposed on violators." (West Virginia *Medical Journal*.)

"How much should the physician be paid by the hour? The wage scale adopted by the Philadelphia County Assistance Board rated physicians at \$1.51 an hour, while it approved \$1.79 for bricklayer foremen, \$1.65 for iron and steel workers, \$1.62 for bricklayers, \$1.60 for marble setters and polishers, and \$1.55 for plasterers." (*Modern Medicine*, published in the *Doctor's Digest*, January, 1940.)

"Dismissal of Dr. Clyde R. Bennett of Los Angeles, physician and psychiatrist at the Camarillo State Hospital, from further employment by the State was asked in a complaint involving a morals charge filed before the California Personnel Board today. Complainant is Thomas W. Haggerty, superintendent and medical director of the hospital. Doctor Bennett was specifically charged with immoral relations with another man. He has ten days in which to file an answer to the charges and to request a hearing before the Board. . . . Defendant was also notified that he has been 'forthwith suspended from the service of the State of California' until the charges can be heard and a decision rendered." (Press dispatch dated Sacramento, May 16, printed San Francisco *Examiner*, May 17, 1940.)

"The trial of Ben K. Glover, 61, operator of an 'electronic health appliances' business in Modesto, has been set for May 29 before a jury in the court of Justice of the Peace Leslie K. Floyd. Glover is at liberty on \$250 cash bail. He is also to be tried at Snelling, May 15, on a similar charge of practicing medicine without a license. Both complaints

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were filed by J. W. Williams, special agent of the State Board of Medical Examiners." (Stockton *Record*, May 11, 1940.) (Previous entry, News Items, May, 1940.)

"Federal Judge A. F. St. Sure today sentenced an Oakland man and his wife and another woman to federal prison terms for passing forged physicians' prescriptions for morphine. Sentenced to serve five years was James Kendall, 34, of 1012 Fourteenth Street. His wife, Eva, 27, and Miss Grace O'Brien, 39, who lived with the Kendalls, were given two-year terms." (San Francisco *Call-Bulletin*, May 11, 1940.)

"Alma Elizabeth Black, who willed her estate to Dr. Nathan S. Housman after having given him much of her fortune, was worth \$38,210 when she died last year, it was revealed in an inventory on file today by Inheritance Tax Appraiser W. A. Breen. Her will is being probated before Superior Judge Frank H. Dunne under an agreement reached in February whereby her two sisters-in-law—Miss Katherine Black, 67, and Mrs. Frances Goepfert, 74, both of 1628 Fell Street, dropped their contest. It was asserted at the time Doctor Housman would relinquish to the elderly sisters \$35,000 in cash and stock worth \$85,000. . . . Breen's inventory showed Mrs. Black, at the time of her death, had \$8,500 in the bank, stocks worth \$29,500 and furniture in her home at 1880 Fulton Street valued at \$210. . . ." (San Francisco *Call-Bulletin*, May 7, 1940.)

"Dr. Rutherford B. Irones, San Diego physician and former mayor, yesterday was sentenced to serve sixty days in the County Jail for an assault on William L. Jaynes, at whose "B" Street hotel Doctor Irones' secretary resided. Once before, when Doctor Irones was convicted on a hit-

(Continued on Page 40)



RABBITS *and* RAGWEED

Rabbits may look alike, but when used to produce antipneumococcic serum the titre may differ widely from animal to animal. Likewise, two lots of ragweed (or any other pollen) may be identical weight for weight, yet differ in content of active principle.

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¹ Cooke, R. A., and Stull, A.: *J. Allergy* 4:87, 1933 and previous papers.

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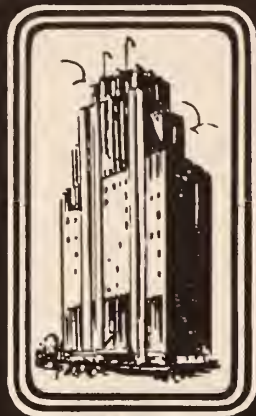
Package	Contents	Total Protein Nitrogen units Supplied	Advantages
Three-Vial Package	Three—3.5-cc. vials—containing 100, 1000, and 10,000 protein nitrogen units per cc. respectively.	38,850	1—Convenience—no diluting or mixing necessary. 2—Economy—enough material for from 15 to 19 doses for one patient. 3—Flexibility of dosage—dosage may be adjusted to suit individual requirements.
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HILTON MANAGEMENT

BOARD OF MEDICAL EXAMINERS

(Continued from Page 33)

run charge involving the manner in which he drove a city car while mayor, he was a prisoner at the County Jail, and at that time installed a dispensary that has been of value to jailers ever since. Doctor Irones accepted his sentence without emotion and entered jail with a smile. Last night he was in a cell block, but there were reports that he soon will have an opportunity to assist Dr. Gerald Banks, jail physician, who has maintained the dispensary started in the earlier term of Doctor Irones." (San Diego Union, May 21, 1940.) (Previous entry, March and April, 1935; August and September, 1939; April, 1940.)

"Dr. Lena Engst Thiriot, Oakland physician, who pleaded guilty to a Federal indictment of sending obscene letters through the mails, yesterday was placed on five years' probation by Federal Judge A. F. St. Sure. . . . The letters, said Assistant United States Marshal Val Mammack, were written in anger because of refusal of the attorneys to help obtain parole for Doctor Thiriot's husband, sent to San Quentin four years ago on a morals charge. . . ." (San Francisco Examiner, June 4, 1940.)

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BALTIMORE, MARYLAND

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Cigarette information worth knowing*

*Philip Morris do not claim to cure
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62.3%

of the cases of irritation of the nose
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Feb. 1935. Vol. XLV, No. 2, 149-154*

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Nursing woman	17-20 mg.
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In securing these necessary daily supplies of dietary iron, unfortunately we cannot be solely guided by the total iron content of the diet. It should be remembered that probably not more than about 60 per cent of the total iron present in a mixed diet can be diverted to the body's uses (2), even though with individual foods this percentage of "ionogenic iron" may be quite high (3). Consequently, in practical nutrition, to obtain an adequate intake of this essential mineral about twice the estimated daily requirement of iron should be received by way of the daily ration.

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(1) 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York, N. Y.

(2) 1939. Food & Life, Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.

(3) 1940. J. Nutrition 19, 449.

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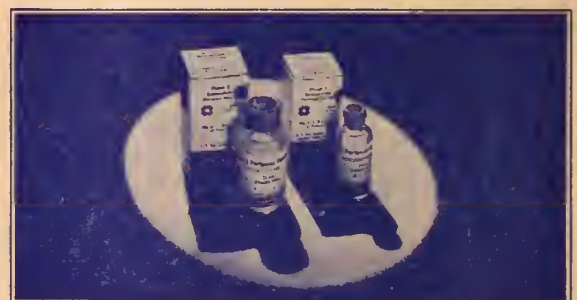
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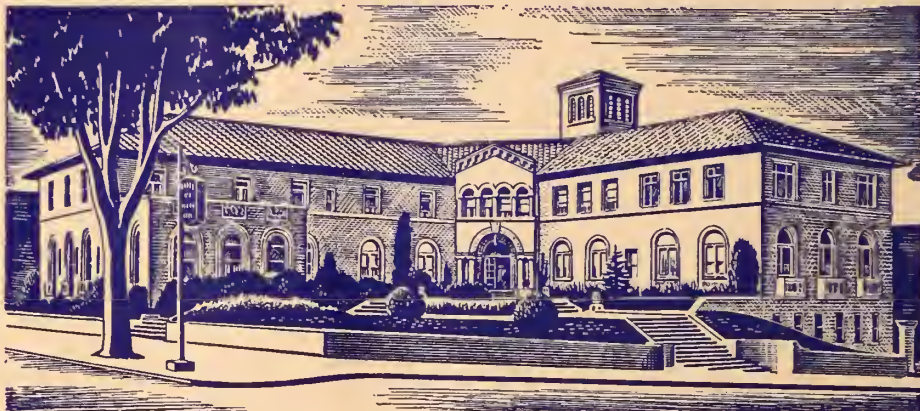
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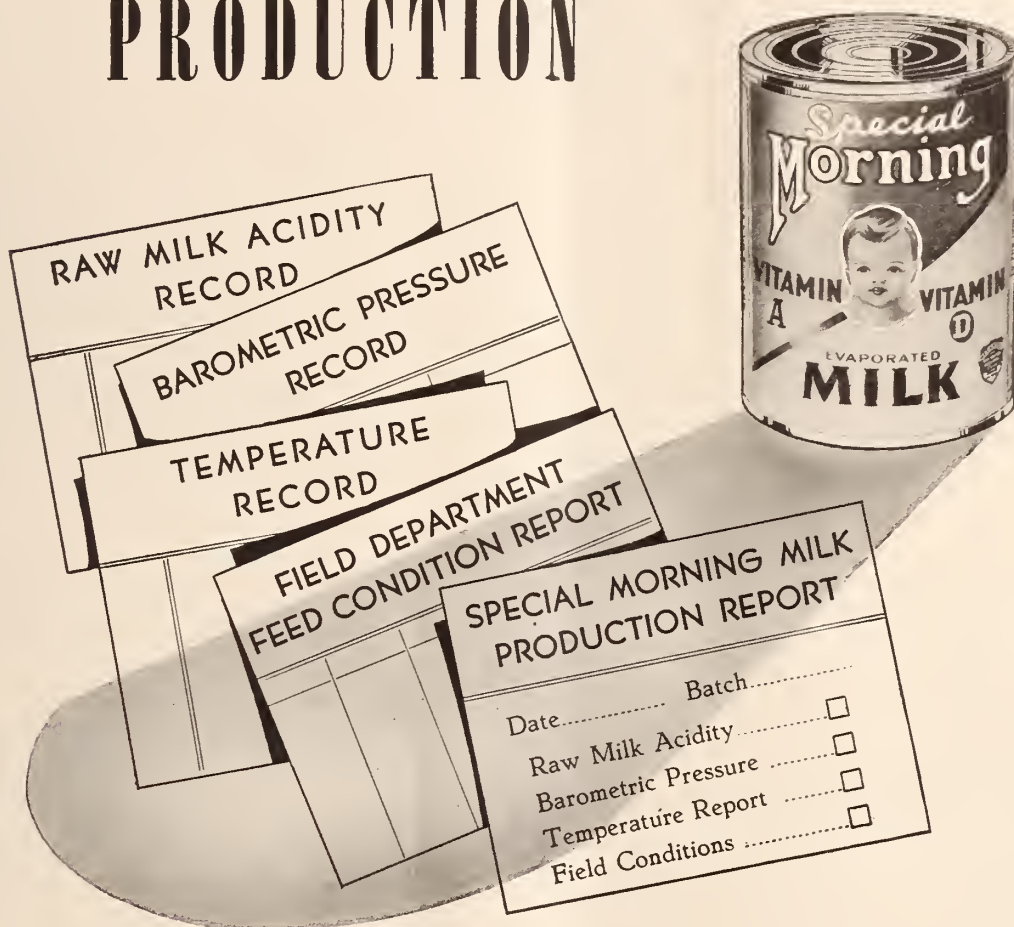
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(Continued on Page 5)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, A. A. Alexander, 1904 Franklin Street, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, William W. Carey, 103 Hazel Street, Gridley.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Kaho Daily, 314 Tenth Street, Richmond.
Secretary, Clifford E. Dietderich, 1306 Pomona Avenue, Crockett.
Meeting, *second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Ray R. Dearborn, First National Bank Building, Madera.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, John N. Chain, Fourth and E Streets, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, Holtville.
Secretary, Claude F. Peters, 722 Main Street, Brawley.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Lloyd S. Bambaue, 705 Home Street, Bishop.
Secretary, Clarence L. Scott, 609 Elm Street, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, C. S. Compton, 428 C Street, Bakersfield.
Secretary, Eric F. Colby, Hopkins Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, Roy E. Thomas, 1136 W. Sixth Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meetings, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Harry N. Hensler, Home Market Building, San Anselmo.
Secretary, Carl W. Clark, 510 B Street, San Rafael.
Meeting, *Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.*

Mendocino-Lake County Medical Society
President, Dallas L. Wagner, 615 Main Street, Fort Bragg.
Secretary, Royal Scudder, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, William E. Fountain, 557 Seventeenth Street, Merced.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Mast Wolison, 215 Franklin Street, Monterey.
Secretary, Arnold Manor, 215 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Frank N. McGreane, Silverado Sanatorium, Calistoga.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, John A. Wood, 605 No. Los Angeles Street, Anaheim.
Secretary, Glenn Curtis, 323 North Pomona Street, Brea.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, William M. Miller, Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, W. Philip Corr, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Norris R. Jones, M. D., 1127 Eleventh Street, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Walter S. Cherry, Rialto.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Joseph Weinberger, Medico-Dental Building, 233 A Street, San Diego.
Secretary, C. V. Bernardini, 1410 Medico-Dental Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, William Reilly, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meetings, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Hugh J. Bolinger, Farmers and Merchants Bank Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton.
Meetings, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. W. Yocom, 732 Thirteenth Street, Paso Robles.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Carl D. Benninghoven, Mills Memorial Hospital, San Mateo.
Secretary, Robert F. Monteith, 18 California Street, Redwood City.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Henry J. Profant, 1421 State Street, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, Merlin T.-R. Maynard, 241 East Santa Clara Street, San Jose.
Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.
Meeting, *Third Wednesday, 8:00 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. F. Giberson, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Clarence C. Gerrard, Redding.
Secretary, Bertram L. Trelstad, 1536 Market Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, Charles Pius, Yreka.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, H. Randall Madeley, 727 Sonoma Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, S. Z. Peoples, 159 Kentucky Street, Petaluma.
Secretary, T. E. Albers, 600 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Richard D. Husband, P. O. Box 709, Modesto.
Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, H. H. Beck, Corning.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, Harry E. Barker, 1484 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Charles F. Keith, Williams.
Secretary, W. J. Blevins, Jr., Woodland.
Meeting, *First Tuesday.*

Yuba-Sutter-Colusa County Medical Society
President, Ben F. Miller, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *First Tuesday.*

(Roster lists continued on advertising page 6)

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University of California Medical Library, Medical Center, San Francisco.

Lane Medical Library (Stanford), 2398 Sacramento Street, San Francisco.

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Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Insurance Association of Approved Hospitals, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; Easton Building, 428 Thirteenth Street, Oakland.

Associated Hospital Service of Southern California, 1151 South Broadway, Los Angeles.

Intercoast Hospitalization Insurance Association, 1127 "J" Street, Sacramento.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 104)

state, the responsibility is up to them; they cannot avoid it; they cannot plead ignorance, for enlightenment, if they need it, will come with the request for it. But we firmly believe that most of those who vote to lower standards and to allow any old sort of freak to treat the sick or injured citizens of California, do so with their eyes open and to placate some of their constituents at the cost of the welfare of the whole people. Merely as citizens who understand, we extend our thanks to every member of the last legislature who worked or voted for proper medical standards, no matter what the result. . . .

From an Original Article on 'Some Typical Experiences with Syphilitic Patients,' by Victor G. Vecki, M.D., San Francisco.—The histories of the cases selected, each represents a group of cases treated in a different way.

(Continued on Page 7)

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, *AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES*, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA, PA.

TWENTY-FIVE YEARS AGO

(Continued from Page 5)

There is no doubt that every single case of syphilis ought to be treated in the best way there is or, in my estimation, treated about as well as Cases 6, 7, and 8, related in the present report. Unfortunately, and as every syphilologist knows only too well, there are many conditions which prevent physician and patient from carrying out the best and ideal treatment in many a case.

Every person of any intelligence when told to be afflicted with syphilis declares at once the intention to do all possible to fight the evil, nothing would be too much, etc. But most of them relent in their zeal so soon as they see themselves free from any symptoms, and think themselves in perfect health. . . .

From an Original Article on "Notes on Angina Pectoris," by Dr. William Watt Kerr, San Francisco.—Angina pectoris, like ascites and dropsy, is a term used to designate a group of symptoms which probably are consequent upon a number of morbid changes reacting upon one another, but the exact interrelationship of which we do not at present understand. Yet the group is one of such importance and severity that it requires special treatment, and consequently angina pectoris is most frequently mentioned as if it were a disease.

The term originally meant a sense of suffocation, strangulation, or constriction in the chest, but this condition is so frequently overshadowed by the most intense and agonizing pain that popularly the first signification is almost forgotten, and pain is the idea suggested to the mind when the words are spoken.

(Continued on Page 9)

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TWENTY-FIVE YEARS AGO

(Continued from Page 7)

Additional difficulties have arisen from poor classification of the cases. . . .

Angina pectoris is, therefore, a symptom of cardiovascular disturbance, just as tachycardia is another indication of various disorders in the same system. . . .

From an Original Article on "Dermatitis Caused by Primula Poisoning," by Douglass W. Montgomery, M. D., and George D. Culver, M. D., San Francisco.—Primula poisoning is probably not frequent, but curiously enough in the past few months we have run across quite a number of instances. Its previous infrequency may have been either due to absolute infrequency or to oversight on our part. In medicine, one usually finds only what one looks for, and in primula poisoning, as we shall see later, the cause must frequently be persistently searched out or it will not be found. The following case illustrates the intensity the disease may assume, and its elusive etiology. . . .

From an Original Article on "The Early Diagnosis of Pulmonary Tuberculosis," by Robert A. Peers, M. D., Colfax.—The title "The Early Diagnosis of Pulmonary Tuberculosis" should probably read "The Earlier Diagnosis of Pulmonary Tuberculosis" because, whether we believe that tuberculosis is essentially an infection of childhood with the later or secondary manifestations in adult life, or whether we believe that most infections take place later in life than childhood, we must all admit that the tubercle bacillus has been implanted and has been nourished and propagated within the human body for months, at least,

(Continued on Next Page)

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HOSPITALS AND SANATORIUMS

The Institutions here listed have announcements in this issue of CALIFORNIA AND WESTERN MEDICINE. For Index, see advertising page 8.

ALEXANDER SANITARIUM Nervous and Mental Diseases Belmont, California	COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	POTTENGER SANATORIUM AND CLINIC For the Treatment of Tuberculosis Monrovia, California
ALUM ROCK SANATORIUM For Treatment of Diseases of the Chest San Jose, California	FRANKLIN HOSPITAL Limited General Hospital Fourteenth and Noe Streets, San Francisco	PARK SANITARIUM Mental and Nervous Alcoholic and Drug Addictions 1500 Page Street, San Francisco, California
CALIFORNIA SANITARIUM For Treatment of Tuberculosis Belmont, California	FRENCH HOSPITAL General Hospital Geary at Fifth Avenue, San Francisco	SAINT FRANCIS HOSPITAL Limited General Hospital Bush and Hyde Streets, San Francisco
CANYON SANATORIUM For Treatment of Tuberculosis Redwood City, California	GREENS' EYE HOSPITAL Consultation, Diagnosis and Treatment of Diseases of the Eye Bush and Octavia Streets, San Francisco	ST. LUKE'S HOSPITAL Limited General Hospital 27th and Valencia Streets, San Francisco
COLFAX SCHOOL FOR THE TUBERCULOUS For the Treatment of Tuberculosis Colfax, California	LARKSPUR CONVALESCENT AND REST HOME For general cases, excluding psychoses 234 Hawthorne Ave., Larkspur	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
	LAS ENCINAS SANITARIUM Nervous and General Diseases Las Encinas, Pasadena, California	TWIN PINES Convalescent and Neuropsychiatric Belmont, California
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Psychiatry

TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

and in some cases for years before the symptoms develop sufficiently to call for treatment or to bring the patient to the physician. Thus it seems rather out of place to speak of early diagnosis when the disease has existed for many months. . . .

From an Original Article on "The Occurrence of Heart-Block in Acute Diseases," by Herbert W. Allen, M.D., San Francisco.—In the last ten years the number of reported cases of heart-block has reached very considerable proportions, due largely to the interest taken in the subject following the successful experimental production of the condition, and to the more general use of graphic methods in the study of cardiac diseases. The great majority of the reported cases are instances of the chronic variety, as usually met with in adult life. That heart-block may occur as a transient or even permanent feature of acute disease at any age is not, I think, very generally understood, nor is the importance of its recognition fully appreciated. . . .

From an Original Article on "Pitfalls in the Diagnosis of Renal Lithiasis," by Martin Krotoszyner, M.D., San Francisco.—In spite of the great strides made in the correct preoperative recognition of surgical renal lesions, and in spite of the many exact methods of examination by which renal surgery of late has advanced to an almost marvelous degree, the diagnosis of surgical kidney lesions is, nevertheless, in many instances very difficult and, not rarely, entirely impossible. The application of the majority or even of all of the many exact methods of examination at our disposal today does not always give reliable results of truly pathognostic value. . . .

From an Original Article on "Pediatric Situation in Europe and the Effect of the War on the Same," by John Adams Colliver, M.D., Los Angeles.—You have asked me to give you a résumé of the pediatric situation in Europe, and the effect of the war on the same. In doing this, I will briefly confine my remarks to my own experience and observation, taking each place in turn, and pointing out the things which to me seem most characteristic. . . .

From an Original Article on "Tuberculosis of the Female Genitals," by J. W. James, M.D., Sacramento.—The most important phase of tuberculosis from a gynecologist's standpoint is, as in so many other branches of medicine, diagnosis. The most frequent of the infections are probably those infecting the organs involved in the excretion of urine; but this brief article deals only with those organs essentially female, viz.: the uterus, tubes and ovaries, and the external genitals. . . .

From an Original Article on "Personal Experience with Cholecystectomy," by Lewis W. Allen, M.D., San Francisco.—In responding to the call for a paper before the society, it is my intention this evening to place before you my experiences in gall-bladder surgery and my conclusions deduced therefrom. I will not attempt any historical review of the subject as that can be found fully developed elsewhere. So also with the etiology, symptomatology, and diagnosis—fascinating as each of these subjects is, it is contrary to the purposes of this paper to enter into their discussion. . . .

From an Article on "Pan-American Medical Congress." Pursuant to an invitation by the President of the United States, authorized by act of Congress approved the third



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Because the control of quality of lenses intended for human vision can be accomplished only by complete control of all factors, Bausch & Lomb manufactures all the glass used in the production of Bausch & Lomb lenses. Here is shown the pouring of a pot of glass for Orthogon lenses. Scarcely 8% of this glass will survive all manufacturing and inspection operations to achieve the high distinction of giving better vision to your patients. *In Soft-Lite, too.*

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of March, 1915, the Seventh Pan-American Medical Congress convened in San Francisco on the 17th of June of this year. Owing to the short time between the authorization of the medical congress by the national Congress, a smaller attendance than was desired was realized, but in spite of the short time Argentina, Brazil, Cuba, Guatemala, Panama, Peru, Salvador, and Venezuela were ably represented by delegates in person, and not a few who could not attend contributed to the support of the meeting by dues and by writing and submitting papers. The object of this special congress is, succinctly: (1) To promote personal and fraternal relations between the members of the medical profession of the Western Hemisphere; (2) To make the medical profession of each country more familiar with the educational, scientific and other medical resources of all the other American countries; (3) To consider problems of sanitation and public health administration of both national and international importance to the countries and colonies concerned; (4) To promote the development of periodical and other medical literature best calculated to promote the interchange of thought, as well as practical scientific coöperation by and between an all-American medical profession; (5) To cultivate the medical sciences. . . .

From an Article on "City Tuberculosis Clinics."—Following in the footsteps of New York, Chicago, Philadelphia, Baltimore, Detroit and Milwaukee, Los Angeles at its recent election has started a division of tuberculosis in the health department; and with the two to one vote of the citizens there the city will have one municipal tuberculosis nurse for every one hundred cases that are registered, if they need supervision and care.

Other cities in California would do well to consider the advisability of following in the footsteps of Los Angeles.

It was shown very clearly in the vote the attitude of the voters toward the establishment of this municipal tuberculosis nursing, and the investment in a public health way to a community cannot be measured. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 104)

until 1944. Doctor Pottenger succeeds Dr. E. M. Pallette of Los Angeles and will serve until 1943. He is medical director of the Pottenger Sanitarium and Clinic and a clinical professor of medicine at the University of Southern California." (Los Angeles *Herald and Express*, June 21, 1940.)

Appointment of Dr. Frank B. Young, Long Beach Surgeon, to the State Board of Health was announced today by Governor Olson. Doctor Young succeeds Dr. Roy Terry." (San Francisco *Call-Bulletin*, June 4, 1940.)

"The eligibility of patients able to pay for hospitalization, to enter the county hospital from communities where there are private hospitals, was questioned this week by Dr. P. S. Winner, new owner of the Fort Jones Hospital. Doctor Winner raised the question when he appeared before the County Board of Supervisors at their regular monthly meeting in Yreka on Tuesday. According to the physician, the county hospital is maintained primarily for the accommodation of patients lacking funds for treatment in private institutions, and is allowed by law to admit paying patients only in case of emergency or where private hospital facilities do not exist. The fact that Scott Valley

(Continued on Page 16)

CLASSIFIED ADVERTISEMENTS

Rates for these insertions are \$4 for fifty words or less; additional words 5 cents each.

Copy for classified advertisements should be received not later than the fifteenth of the month preceding issue.

COACHING FOR STATE BOARDS — MEDICAL AND Dental. Arthur H. White, M. D., Suite 1005, Flood Building, San Francisco.

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PHYSICIAN WANTED TO TAKE OVER NEW SUITE offices, six rooms just completed, one story modern professional building—\$50 month rent. Exceptional location, fast growing section Los Angeles City; proportion, one doctor 1,200 population; young salaried class home owners, adjacent movie and aeroplane industry. Marvelous chance for young internist just starting practice. Sub-lease by physician due to sickness. Address, Physician, Suite 209-211, 5504 Hollywood Boulevard, Hollywood, California, or phone GR 5810.

Cites First Relapsing Fever Case to Be Reported in Oklahoma.—The first case to be reported in Oklahoma of relapsing fever, an acute infectious disease often found in certain tropical countries, but rarely observed in the United States, is cited by Dr. W. P. Neilson, Enid, Oklahoma, in *The Journal of the American Medical Association*.

The disease is characterized by recurrent attacks of fever and chills. The causative microorganisms are spirochetes of the genus *Treponema*, generally transmitted to man by means of ticks and lice. Although Doctor Neilson found the organism in his patient's blood, he was unable to determine the origin of the infection. "The patient has not been away from her immediate vicinity," he says. "No foreign guest has visited the home. There is no history of an insect bite or any other external lesion. The patient lives on a farm in the wheat plains area; rodents are very few. She does no outside farm work."

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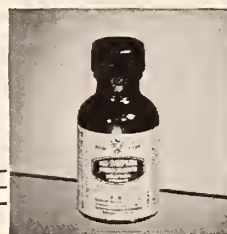
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BOOK REVIEWS

BOOKS RECEIVED

Immune-Blood Therapy of Tuberculosis. With Special References to Latent and Masked Tuberculosis. By Joseph Hollos, M. D. Cloth. Pp. 197. Price, \$2.50. Boston: Bruce Humphries, Inc., 1938.

Handbook of Treatment. By Edward A. Mullen, P. D., M. D., F. A. C. S., Instructor in Materia Medica, University of Pennsylvania Medical School; Assistant Professor of Pharmacology and Physiology, Philadelphia College of Pharmacy and Science; Lieutenant Commander, Medical Corps, U. S. Naval Reserve. Foreword by Horatio C. Wood, Jr., Professor of Therapeutics in University of Pennsylvania, Graduate School of Medicine; Professor of Pharmacology and Physiology, Philadelphia College of Pharmacy and Science. Second Revised Edition. Cloth. Pp. 707. Price, \$4.50. Philadelphia: F. A. Davis Company, 1940.

Supplement to Materia Medica Drug Administration and Prescription Writing. By Oscar W. Bethea, M.D., Ph.G., Ph. M., F. C. S., F. A. C. P. Fifth Revised Edition. Paper. Pp. 39. Philadelphia: F. A. Davis Company, 1939.

The Emperor's Itch. The Legend Concerning Napoleon's Affliction with Scabies. By Reuben Friedman, M. D., Assistant Professor of Dermatology and Syphilology, Temple University School of Medicine, Philadelphia. Cloth. Pp. 82 with ten illustrations. Price, \$1.50. New York: Froben Press, 1940.

Handbook of Hearing Aids. By A. F. Niemoeller, A. B., M. A., B. S., Author of "The Complete Guide for the Deaf-

ened." Foreword by Harold Hays, M. D., F. A. C. S., Author of "The Modern Conception of Deafness." Cloth. Pp. 156. Price, \$3. New York: Harvest House, 1940.

Complete Guide for the Deafened. By A. F. Niemoeller, A. B., M. A., B. S., Author of "Handbook of Hearing Aids," etc. With a Foreword by Harold Hays, M. D., F. A. C. S., Author of "The Modern Conception of Deafness," etc. Cloth. Pp. 256. Price, \$3. New York: Harvest House, 1940.

The Era Key to the USP XI & NF VI. Fifth Edition, Revised by Lyman D. Fonda, Professor of Pharmacy, Brooklyn College of Pharmacy, Long Island University. Cloth. Pp. 320. Price, \$1. Newark: The Haynes & George Co., Inc., 1939.

Legal Guide for American Hospitals. By Emanuel Hayt, LL. B., and Lillian R. Hayt, M. A., J. D., of the New York Bar. Prepared in Collaboration with the Council on Government Relations of the American Hospital Association. Cloth. Pp. 608. New York: Hospital Textbook Company, 1940.

A Manual of Otology, Rhinology and Laryngology. By Howard Charles Ballenger, M. D., F. A. C. S., Assistant Professor of Otolaryngology, Northwestern University School of Medicine, Chicago, Illinois. Cloth. Pp. 302, illustrated with 90 engravings and 4 color plates. Price, \$3.75. Philadelphia: Lea & Febiger, 1940.

The Diagnosis and Treatment of Pulmonary Tuberculosis. By John B. Hawes, 2d, M. D., Late President of the Boston Tuberculosis Association; Director of the National Tuberculosis Association; Former Instructor in the Graduate School of Medicine, Harvard University, and Moses J. Stone, M. D., Assistant Professor of Medicine, Boston University, School of Medicine; Physician to the Chest Clinic of the Massachusetts Memorial Hospitals, Boston, Massachusetts; Physician to the Tuberculosis Clinics of

the Boston Health Department; Assistant Physician Beth Israel Hospital. Second Edition. Revised by Dr. Moses J. Stone with a Foreword by Richard C. Cabot, M. D. Cloth. Pp. 260, illustrated with 75 engravings. Price, \$2.75. Philadelphia: Lea & Febiger, 1940.

Modern Dermatology and Syphilology. By S. William Becker, M. D., Associate Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago, and Maximillian E. Obermayer, M. D., Assistant Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago. Cloth. Pp. 871, with 461 illustrations in text and 32 full color plates. Price, \$12. Philadelphia: J. B. Lippincott Company, 1940.

Synopsis of the Principles of Surgery. By Jacob K. Berman, A. B., M. D., F. A. C. S., Assistant Professor of Surgery, Indiana University School of Medicine, Indianapolis. Cloth. Pp. 615, with 274 illustrations. Price, \$5. St. Louis: The C. V. Mosby Company, 1940.

Principles of Surgical Care, Shock and Other Problems. By Alfred Blalock, M. D., Professor of Surgery, Vanderbilt University School of Medicine, Nashville, Tennessee. Cloth. Pp. 325, illustrated. Price, \$4.50. St. Louis: The C. V. Mosby Company, 1940.

An Introduction to Biochemistry. By William Robert Fearon, M. A., Sc. D., M. B., F. I. C., Fellow of Trinity College, Dublin, Member of the Royal Irish Academy. Second Edition. Cloth. Pp. 475. St. Louis: The C. V. Mosby Company, 1940.

American Doctors of Destiny. A Collection of Historical Narratives of the Lives of Great American Physicians and Surgeons Whose Service to the Nation and to the World Has Transcended the Scope of Their Profession. By Frank J. Jirka. With an Introduction by Harold W. Camp and Twenty Portraits by Raymond Warren. Cloth. Pp. 361. Price, Trade Edition, \$3.75; Limited Edition, \$7.50. Chicago: Normandie House, 1940.

It Is Your Life. Keep Health, Stay Young, Live Long. By Max M. Rosenberg, M. D., Member American Medical Association and New York County Medical Society. Formerly in Charge of Clinical Laboratory O. P. Department, Beth Israel Hospital, Clinical Assistant Internal Medicine, Beth Israel Hospital, Clinical Assistant Pediatrics, Gouverneur Hospital. Cloth. Pp. 450. Price, \$2.50. New York: The Scholastic Book Press, 1940.

Graduate Medical Education. Report of the Commission on Graduate Medical Education. Cloth. Pp. 304. Chicago: The University of Chicago Press, 1940.

Dermatologic Therapy in General Practice. By Marion B. Sulzberger, M. D., Assistant Clinical Professor of Dermatology and Syphilology, Skin and Cancer Unit of the New York Postgraduate Medical School and Hospital of Columbia University; Associate Attending Dermatologist, Montefiore Hospital, New York City, and Jack Wolf, M. D., Attending Dermatologist and Syphilologist, Skin and Cancer Unit of the New York Postgraduate Medical School and Hospital of Columbia University; Director of Dermatology, New York City Cancer Institute. Cloth. Pp. 680, illustrated. Price, \$4.50. Chicago: The Year Book Publishers, Inc., 1940.

The Endocrine Therapy in General Practice. By L. Sevinghaus, M. D., F. A. C. P., Professor of Medicine, University of Wisconsin, Madison, Wisconsin; Editor, Department of Endocrinology, The Year Book of Neurology, Psychiatry and Endocrinology. Cloth. Pp. 239. Price, \$2.75. Chicago: The Year Book Publishers, Inc., 1940.

Manual of Medical and Surgical Emergencies. Edited by J. C. Geiger, M. D., Director, Department of Public Health, City and County of San Francisco, California. Cloth. Pp. 199. Price, \$2.50. San Francisco: J. W. Stacey, Inc., 1940.



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deal independently in the best of
each line. Exceptionally generous
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BOOK REVIEWS

Diseases of the Skin. By Richard L. Sutton, M.D., Sc.D., LL.D., F.R.S. (Edinburgh), Professor of Dermatology, University of Kansas, School of Medicine; and Richard L. Sutton, Jr., A.M., M.D., L.R.C.P. (Edinburgh), Associate in Dermatology, University of Kansas, School of Medicine. Cloth. Pp. 1549, with 1,452 text illustrations and 24 color plates. Tenth Edition, Revised, Enlarged and Reset. Price, \$15. St. Louis: The C. V. Mosby Company, 1939.

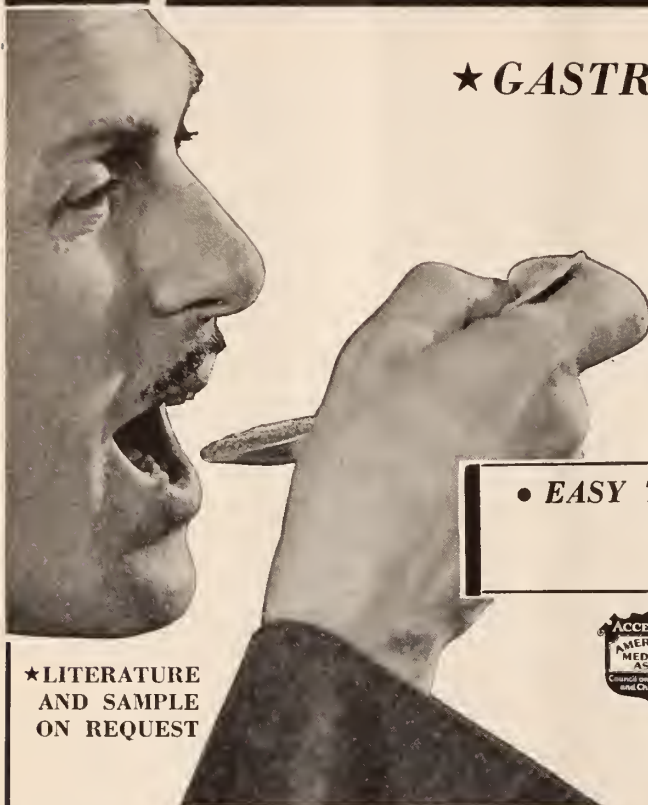
With the publication of the tenth edition of "Diseases of the Skin," the Doctors Sutton have contributed a valuable volume on the subject. The new edition departs in manner of presentation from the conventional, and attempts to "... tie descriptions and concepts of skin diseases with general medicine and biology." And again, "Skin diseases are visible tissular activities." This new approach should prove of definite value to the thinking general practitioner

(Continued on Next Page)

A RATIONAL *Ulcer Therapy*

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★ Prepared under license from
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BOOK REVIEWS

(Continued from Preceding Page)

or specialist, and encourage him to associate the objective findings with systemic and tissue responses.

The presentation is informal and direct; the descriptive material is appropriately and completely illustrated. There are 1,473 illustrations, 21 of which are in color. The authors point out that there has been a 100 per cent increment in the number of words, and at least 7,000 bibliographic entries since the ninth edition (1935). The bibliography is remarkable in itself, representing a wide source of information and an earnest effort on the part of the authors to present a complete and unbiased work. However, some readers may have difficulty in tracing the sources of textual references, due to the print used and the arrangement of the bibliography. This might be remedied by the use of bold-faced type and an alphabetical listing of the names of authors.

The publishers deserve praise for the excellent binding—so desirable for a volume of this size.

The book is heartily recommended to students and practitioners alike.

Textbook of Nervous Diseases. By Robert Bing, Professor of Neurology, University of Basel, Switzerland. Translated and Enlarged by Webb Haymaker, Assistant Clinical Professor of Neurology and Lecturer in Neuro-Anatomy, University of California. From the Fifth German Edition. Cloth. Pp. 838, with 207 illustrations, including nine in color. Price, \$10. St. Louis: The C. V. Mosby Company, 1939.

This work answers the requirements demanded of a textbook in that it is easily read, is concise and complete in its scope, and embodies the latest information on the subjects covered.

The chapters on psychoneuroses are far below the high standard maintained throughout the rest of the book.

The treatment of hysteria is covered in two pages, with nothing new offered on the subject.

All in all, the book should be a worth-while addition to any medical library.

R. E. G.

BOARD OF MEDICAL EXAMINERS

(Continued from Page 11)

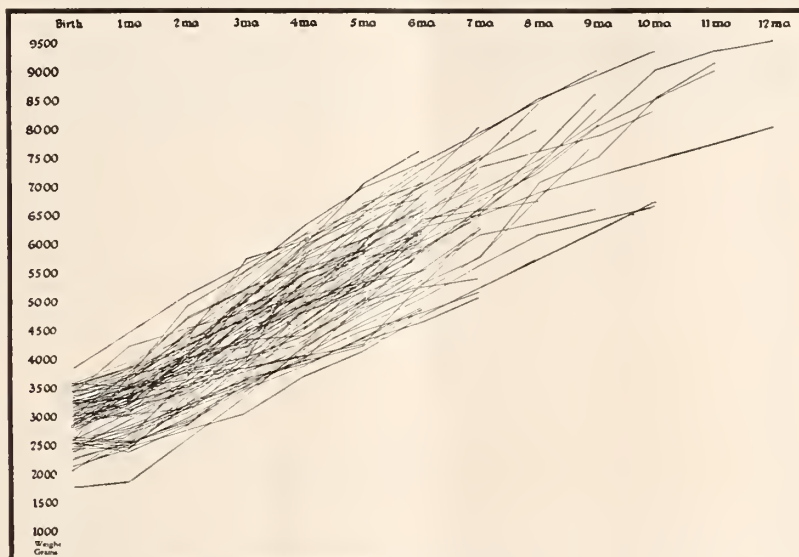
has two hospitals, he held, made residents of the valley ineligible to enter the county institution as paying patients. The same restrictions apply, he stated, to other communities in the county where there are private hospitals. . . . It has been the practice in the past to allow any non-indigent patients who wished to enter the hospital to do so as a paying patient, the Board holding that, since there was no hospital in Yreka, this was permissible. . . ." (Etna Mills *Sentinel*, June 6, 1940.)

"Chance of recovering from blood poisoning is twice as good today as it was four years ago, thanks to the chemical remedies of the sulfanilamide group, Dr. Wallace E. Herrell and Dr. Alex E. Brown, Rochester, Minnesota, announced at the meeting today of the American Medical Association. Those who are treated adequately have seven out of ten chances to recover, as against seven out of ten chances of dying if inadequately treated. Before these drugs were available, about one-third of the patients recovered. . . . Of those who get this chemical, nearly 60 per cent recover. . . ." (News dispatch dated New York, June 14, and published in the San Francisco *News*, same date.)

"Dr. Harold M. Engelhorn, 27-year-old physician of San Diego, yesterday was found guilty by Municipal Judge Leo Freund of stealing linens and surgical instruments from the General Hospital during his internship. Authorities accused the doctor of taking sheets, blankets, uniforms

(Continued on Page 18)

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These weight curves represent the progress of consecutive infants fed on Similac for six months or longer at a well known hospital. Notice the low initial loss, the rapid return to birth weight, and the consistent gain thereafter. There was not a single instance of gastro-intestinal upset in the group. Name of hospital on request.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 16)

and other equipment from the Hospital last May 10. Doctor Engelhorn and his wife, Marjorie, testified under examination by the attorney, William J. Kenney, that they merely used the linens in their home and intended to return the equipment as soon as they moved to San Diego. Judge Freund ordered the physician to return for probation hearing and sentence on June 28." (Los Angeles Times, June 15, 1940.)

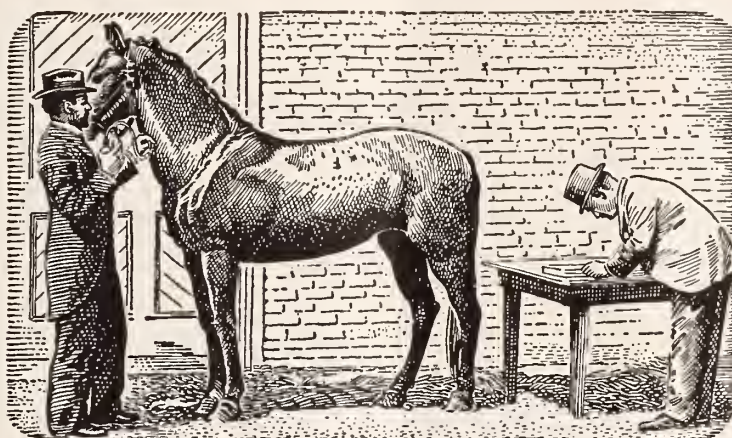
"The record of Dr. Harold M. Engelhorn, recently convicted of petty theft of instruments and linen of small value from General Hospital, was legally cleared today by Municipal Judge Leo Freund. He granted the motion of Attorneys William Kenney and Frank Montgomery to

allow the young doctor to withdraw his guilty plea and enter a plea of not guilty. The court set aside the judgment and discharged the defendant. . . ." (Los Angeles Herald and Express, July 9, 1940.)

"Conviction of William H. Neher, 67-year-old La Verne 'cosmic force healer,' on three counts of practicing medicine without a license, was upheld by the appellate department of the Superior Court in a decision forwarded and on file today with the local Justice Court. Neher was convicted by a jury last October 14 after a four-day trial before Judge Thomas R. Reed of West Covina, sitting for Judge Will G. Fields in the local Justice Court. He was sentenced to pay a total of \$600 in fines, but payment was suspended pending outcome of the appeal in Superior Court. . . . The decision specifically upheld Judge Reed's action in denying Neher a new trial, and declared all other appeals dismissed. 'Because of the number of matters enmeshed in the appellant's dragnet,' the court said, 'we make no comment on any point presented or ground set forth other than to say that we find the convictions amply supported by the evidence.' The complaint against Neher was brought by S. W. Brooks, investigator for the State Board of Medical Examiners. . . . In its verdict, the jury found Neher guilty on three

counts, not guilty on two, and previously acquitted on one count. The State in its complaint and in testimony of its witnesses charged that Neher used a 'cosmic force machine' for the alleged diagnosis and treatment of human ailments. Neher, in his testimony, denied giving treatments or making diagnosis, contending the healing was a 'harmonizing of the cosmic body with the life forces,' through the machine, which he called a 'cosmic rectifier.' Highlight of the trial was testimony of the Rev. Joe Jeffers, who only a short time before had been acquitted in a sensational Los Angeles morals case. As part of his testimony, he claimed for himself the ability to predict the future and to project his thoughts half way round the world. With denial of his appeal, Neher now must pay the fines imposed by the local court." (Pomona Progress-Bulletin, May 30, 1940.) (Previous entries October, November and December, 1939.)

(Continued on Page 20)



*Injecting the first "diphtheria horse"
at the Parke-Davis Laboratories.*

The young doctor who called on Von Behring

The year—1894. Treatment of diphtheria was largely a matter of topical applications to the throat, and "watchful waiting." Then came the news of von Behring's discovery of diphtheria antitoxin.

Dr. E. M. Houghton, a brilliant new member of the Parke-Davis staff, was promptly sent to Vienna—to learn first-hand from the great scientist the details of diphtheria antitoxin production and use. Soon Parke, Davis & Company established the first commercial biological laboratory in America, and today holds U. S. License No. 1 for the manufacture of biological products for human use.

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"GIVE THE PATIENT A BREAK"



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to your patients. Your instructions to our medical staff will be followed in detail.

The Hot Waters, Mineral Steam Caves and Mud Baths are the equal of the best spas in the world. A cordial invitation to be our guest is extended to subscribers of this magazine and members of the California Medical Association. Complimentary rooms and baths will be available on request.

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 18)

"Acting on information that some doctors, nurses and internes of Los Angeles General Hospital have systematically looted the hospital of as much as \$100,000 worth of equipment, Detective Lieutenants M. S. Swan and E. W. Smith announced today their intention of seeking 'John and Jane Doe' warrants to search employees' living quarters. Already under arrest was Harold M. Englehorn, former interne, who pleaded guilty to petty theft before Municipal Judge Newell Carnes, and was said to have told officers that he believed it the general practice at the hospital for some doctors, nurses and other employees to 'help themselves' to equipment. Englehorn, who is 27, left the hospital's employ only a few days ago and was arrested yesterday in San Diego. He was brought to Lincoln Heights Jail. Among expensive equipment said to be missing were fifty to sixty microscopes, valued up to \$600; an operating table, blood-pressure gauging and other instruments, and an undetermined quantity of sheets, beds, bedding, convalescent equipment and sickroom supplies. Officers said that in seeking the warrants they threw no particular employee under suspicion, but intended a routine check of all employees who might have had access to the equipment. The officers found some towels, pillow cases and a hospital surgical

instrument in a garage on Johnston Street, near the hospital. The garage was padlocked with a county padlock. Englehorn, the officers said, admitted taking the articles and said he left the hospital because he found it impossible to support his wife and child on the \$10 a month paid to internes. He also disclosed that employees at the hospital 'borrowed' the hospital linen and then returned it to that institution to be laundered. Officer Swan said he believed the arrest of Doctor Englehorn would be climaxed with startling developments, and that the investigation would continue for 'two or three more months.'" (Los Angeles *Herald and Express*, May 18, 1940.)

"T. P. Hunter, agent for the State Board of Medical Examiners, yesterday arrested two persons here on charges of practicing medicine without proper licenses. Accused were Harry Alverton Chase, 44, Los Gatos, and Joseph P. Redding, 500 Pacific Avenue. Bail of both was set at \$1,000 bond, or \$100 cash pending hearing before Justice of the Peace W. A. Deans tomorrow." (Santa Cruz *News*, May 30, 1940.)

"An Oakland woman physician, Dr. Lena Thiriot, was last Monday placed on five years' probation in San Fran-

(Continued on Page 22)



Are You FEEDING



a Suitable FAT?



Yes, Some Fats Do Upset Them. Yet a proper fat is an essential part of every infant's diet. The addition of carbohydrate cannot compensate for the absence of a sufficient amount of a suitable fat.

SMA fat resembles human milk fat—has the same chemical and physical characteristics. And because SMA fat is like human milk fat the SMA carbohydrate is lactose, the only sugar present in human milk.

The percentages of fat, protein, carbohydrate and ash are the same as those in human milk and when prepared according to the physician's directions SMA is essentially similar to human milk.

Therefore, SMA may be fed to normal full-term infants without modification or change for the same reason that it is not necessary to modify human milk.



Normal infants relish SMA—digest it easily and thrive on it.

Bequest Forms: Unto the California Medical Association*

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$—— to be known as the —— Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR CASH BEQUEST

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the —— Gift, the following described real property situate in the County of ——, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

86c out of each \$1.00 gross income
used for members benefit

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Hospital, Accident, Sickness

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For ethical practitioners exclusively
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LIBERAL HOSPITAL EXPENSE COVERAGE

For
\$10.00
per year

\$5,000.00 ACCIDENTAL DEATH

For
\$33.00
per year

\$25.00 weekly indemnity, accident and sickness

\$10,000.00 ACCIDENTAL DEATH

For
\$66.00
per year

\$50.00 weekly indemnity, accident and sickness

\$15,000.00 ACCIDENTAL DEATH

For
\$99.00
per year

\$75.00 weekly indemnity, accident and sickness

38 years under the same management

\$1,850,000 INVESTED ASSETS

\$9,500,000 PAID FOR CLAIMS

\$200,000 deposited with State of Nebraska for protection of our members.

Disability need not be incurred in line of duty—benefits from the beginning day of disability.

Send for applications, Doctor, to

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 20)

cisco federal court on charges of sending obscene letters through the mail. Doctor Thriot had previously been a correspondent with Judge Forrest L. Bentzien of Santa Clara, whom she had called a "crazy bird" with less disastrous results. The doctor was ordered by Judge A. F. St. Sure to 'refrain from writing abusive or profane letters to any person.' This included Judge Bentzien, who Mrs. Thriot had berated in a letter regarding a civil suit in his court. . . . During Doctor Thriot's trial, she was examined by a psychiatrist, who pronounced her sane, but said she had certain mental fixations, which merited her being shown some consideration." (San Jose County Review, June 11, 1940.)

"St. Louis Estes, health food lecturer, who was convicted last week of practicing medicine without a license, yesterday was fined \$1,500 and sentenced to 150 days in the County Jail by Municipal Judge J. E. White. Arguments on granting a new trial for the lecturer, sought for him by Attorney Alexander Mooslin, were set for tomorrow afternoon by Judge White. In the event a new trial is denied, Mooslin indicated, Estes' conviction on ten counts of practicing medicine without a license will be appealed to the Superior Court. Passing sentence, Judge White fixed a fine of \$150 and a jail term of 150 days for each of the ten counts, but ordered the jail terms to run concurrently. Pending arguments on the new trial, Estes was freed on \$500 bail." (San Francisco Examiner, June 11, 1940.) (Previous entries, May, 1930; November, 1935; March, 1936; December, 1938; February, November, 1939, and May, 1940.)

(Continued on Page 25)

Three servings per day of COCOMALT comprise an extremely valuable means of supplementing vitamins and minerals in both normal and therapeutic diets. The customary daily ration of three servings of COCOMALT contains:

Vitamin A	2400 I. U.
Vitamin B ₁	225 I. U.
Vitamin G	150-225 S. B. U.
Vitamin D	402 I. U.
Calcium	450 mg.
Phosphorus	480 mg.
Iron	15 mg.



Cocomalt Alone Gives High Nutritional Value

In almost every instance COCOMALT is served with milk . . . yet the nutritional value of milk may vary to such an extent through the seasons that an analysis of COCOMALT *and* milk may prove misleading. The actual analysis of vitamin-mineral rich COCOMALT (determined by monthly bio-assay) is so well controlled that it is constant at *all* seasons.

The rich full flavor of COCOMALT is an added incentive to both young and old to drink milk. Quick energy . . . body-building nutrients are all present in this malted food dietonic.

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WEEKS of acute misery, or weeks of comparative comfort? To the hay fever sufferer 'Benedrine Inhaler' often makes just that difference.

Illustrative motif based on Balyeat's Allergic Diseases: Their Diagnosis and Treatment, 4th edition. Copyright, F. A. Davis Company, Publishers.



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Each tube is packed with amphetamine, S.K.F., 325 mg.; oil of lavender, 97 mg.; menthol, 32 mg. 'Benedrine' is S.K.F.'s trademark, Reg. U. S. Pat. Off.



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 22)

"Here is something new as the basis for a new trial plea: St. Louis Albert Estes, the raw food advocate, went before Municipal Judge White and asked the court to invalidate a jury guilty verdict, returned last Monday because one of the jurors failed to reveal that she tried him in 1938 as a member of another jury. On both occasions Estes was accused of practicing medicine without a license. The earlier trial resulted in a deadlocked jury; he was convicted last week and sentenced to a 150-day jail term and a \$1,500 fine. Counsel for Estes named the juror who served in both cases as Mrs. Florence Bartlett, 217 Gough Street, and charged, through witnesses, that she had led the demand for Estes' conviction in the earlier trial. . . . Mrs. Bartlett herself was called to the stand and explained: 'When I was examined for this case, I had no recollection that I had served in the other Estes trial. I didn't realize until this case was under way that I had been a member of the other jury. I had no opinion as to guilt or innocence in this case until it was submitted.' . . ." (San Francisco Chronicle, June 13, 1940.)

"St. Louis Estes, raw food advocate, who was recently convicted and sentenced to 150 days in county jail for practicing medicine without a license, was granted a new trial by Municipal Judge J. E. White today. The motion was granted, the Court said, because a woman juror had previously sat in judgment against Estes. . . . Date for new trial was set for July 9 and bail raised from \$100 to \$250." (San Francisco News, June 21, 1940.)

"Dr. St. Louis Estes, health food lecturer, Wednesday faced \$25,592 in federal income tax liens filed in United

States District Court by Tax Collector Clifford G. Anglim. The tax covered the year 1929, with interest to accrue from December, 1934. Estes, recently convicted on ten counts of practicing medicine without a license, is scheduled to appear before Municipal Judge J. E. White on July 11 to have a date set for his retrial." (San Francisco Recorder, July 5, 1940.) (Previous entries, May, 1930; November, 1935; March, 1936; December, 1938; February and November, 1939; May and July, 1940.)

"Dr. Rutherford B. Irones, former mayor, on a modification of sentence today won release from the county jail, where he has been serving a sixty-day sentence for assault on a downtown hotel owner. Irones was found guilty of battery on W. L. Jaynes, B Street hotel operator, and was sent to the jail thirty days ago. His attorney today, in municipal court, moved for a modification on the grounds that Irones, a physician, has several elderly patients who need his special care and who might suffer if Irones is unable to administer his prescribed course of treatment to them. Municipal Judge Dean Sherry granted the modification. Irones once before served a county jail sentence for hit-run driving and more recently was acquitted of stabbing a young woman friend in the back at the San Diego Club." (San Diego Tribune-Sun, June 19, 1940.) (Previous entries, March and April, 1935; August and September, 1939; April and July, 1940.)

"The manslaughter conviction of Dr. Claude C. Long as a result of the alleged abortion death of Genevieve Arganbright, was upheld yesterday by the State Supreme Court. The fourteen-page majority opinion of the court adopted in part the ruling of the District Court of Appeal

(Continued on Next Page)

The Difference— and there Is a DIFFERENCE!

"The difference between learning to drive a car and learning to play golf is that when you are learning to drive a car you sometimes hit something."

—From MOTORLAND.

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OAKLAND

BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

made last November. Justice Jesse W. Carter filed a dissenting opinion." (San Francisco Recorder, June 28, 1940.) (Previous entries, July, September, October, November, December, 1937; February and August, 1938.)

"Two men, charged with illegal practice of medicine without a license, Joseph P. Redding and Albert Chase, D. C., appeared before Justice W. A. Deans yesterday. The charges were preferred by Thomas P. Hunter of the State Medical Board. Redding was represented by Attorney Stanford Smith, and on motion of his attorney was given a week to enter his plea. He was practicing massage and allegedly he gave pills. Albert Chase, D. C., alleged he was a doctor of science and his treatment was dietetic and religious. . . ." (Santa Cruz Sentinel, June 2, 1940.)

"Articles of incorporation for the Medical-Dental Life Assurance Company, to operate in the insurance business, were filed in Sacramento by a group of local men, headed by Louis Oneal, well-known attorney, who said he would be president of the new firm. Oneal said the new insurance company would offer health and life insurance and would be the first company of its kind to offer dental care in an insurance policy. . . . Medical head of the new firm will be Dr. Walter B. Coffey, retired chief surgeon of the Southern Pacific Railroad. . . . The corporation was capitalized at \$500,000, the United Press said." (San Jose News, June 27, 1940.)

"Convicted on all six counts of perjury, offering and preparing false evidence, Dr. Nathan S. Housman was held in the county jail without bail today. The San Fran-

cisco physician was convicted by a superior court jury which deliberated two and a quarter hours before returning the verdict to Superior Judge Lile T. Jacks. Doctor Housman was pale and nervous when the verdict was read. His attorneys announced that they would move for a new trial tomorrow. Should their motion be denied, Judge Jacks will sentence Doctor Housman at that time. . . . He faces one to fourteen years in prison on each of the two counts of perjury and from six months to five years on each of the other four counts of preparing and offering false evidence—a possible aggregate maximum of forty-eight years. The trial arose from evidence of narcotic prescriptions given at a previous municipal court trial for failing to keep proper narcotics records. Doctor Housman's appeal from the municipal court conviction, which resulted in a \$750 fine and ninety-day jail sentence, was to come up today in the appellate division of the superior court. After reading of the verdict in the superior court trial, Attorney Nathan Coghlan, defense counsel, argued heatedly for admission of Doctor Housman to bail, which was denied by Judge Jacks. Assistant District Attorney John J. McMahon, who prosecuted Doctor Housman, said in his final argument that it was the state's aim to 'keep the medical profession in the high place it now enjoys.' As the result of the new conviction, state medical authorities may file a new complaint against Doctor Housman before the Board of Medical Examiners, the Attorney-General's office said." (San Francisco Call-Bulletin, June 12, 1940.) (Previous entries, November and December, 1932; July, 1933; January, 1937; September, 1938; February, October, and December, 1939; January, February, and April, 1940.)

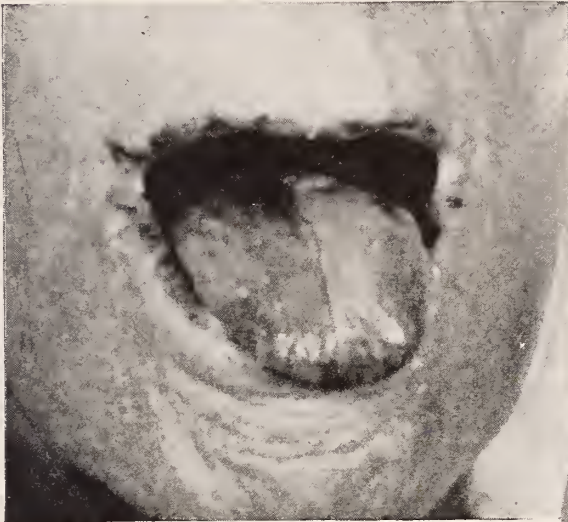
"One of the Nazi 'business men and technicians' who arrived here on June 16 aboard the liner Asama Maru was

(Continued on Page 28)

STUDIES IN THE AVITAMINOSES



This page is the eighth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the July 20 issue of The Journal of the American Medical Association.



Coexisting riboflavin deficiency and pellagra, showing cheilitis and the characteristic glossitis.

THE manifestations of riboflavin deficiency in man have been recognized as such only recently. Frequently they occur in conjunction with pellagra, and consequently the characteristic lesions may not be apparent until the pellagra has been overcome.



The cheilitis of ariboflavinosis. Note fissures at angles of mouth.

The Clinical Manifestations of Riboflavin Deficiency

THE most prominent lesion of riboflavin deficiency is a cheilitis characterized by reddening of the lips due to exfoliation of the epithelium, and radiating fissures at the angles of the mouth. There may also be seborrheic lesions in the nasolabial fold and on the alae nasi. According to Krause, Sydenstricker, Sebrell, and

Cleckley, riboflavin deficiency produces a magenta color of the tongue. As stated by these investigators, when riboflavin and nicotinic acid deficiencies occur in the same individual, the fiery red tongue of pellagra may change under the influence of nicotinic acid to a magenta color which disappears only after riboflavin therapy.



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 26)

arrested last night in Los Angeles under circumstances which were said to have such sensational ramifications that federal authorities immediately communicated with Washington. The prisoner is Dr. Herbert Hoehne, tall, powerfully built blond, who was held by the Federal Bureau of Investigation on the charge that he failed to register himself as a German agent, as required by a new federal law. Doctor Hoehne, who when interviewed here protested that he could not speak English, immediately made emphatic denials of the charge—in English—and demanded permission to get in touch with Fritz Wiedemann, German Counsel-General in San Francisco. . . ." (San Francisco Examiner, June 27, 1940.) The office of the Board of Medical Examiners has no record of anyone by the name of Dr. Herbert Hoehne as holding medical credentials, nor does his name appear in the 1940 directory published by the American Medical Association.

"Mattie E. Wilcox, sixty-four, yesterday pleaded guilty in police court to charges of posing as a registered nurse and practicing medicine without a state certificate. Judge Milan E. Ryan suspended sentences of \$25 or five days on each count on condition that the woman study carefully the state laws applying to her business. Her address was given as 1253 Seventh Street, and the charges were filed by state officers who have been investigating various 'healing systems' in business in Southern California, court records showed." (Santa Monica Outlook, June 8, 1940.)

"Appointments of administrative staff members for the San Francisco unit of the State Defense Council were an-

nounced by Superior Judge Everett C. McKeage yesterday. The jurist was named chairman of the unit by Governor Olson some weeks ago. The appointments: Administrative assistant, Edward Sharkey . . . County Publicity Director, Eugene B. Block . . . County Transportation Director, James Cronin . . . County Medical Director, Dr. Alvin E. Cerf, member of the State Board of Medical Examiners. County voluntary recruiting board organizer, Claudius A. Marckley. . . . The state organization, first of its kind in the nation, will set up the machinery for making volunteers available for immediate service in case of war or other emergency, Judge McKeage said." (San Francisco Chronicle, July 4, 1940.)

"It wasn't just a three-to-thirty-year sentence Superior Judge Lile T. Jacks imposed on James Allen yesterday—along with it went the Judge's brand that 'You're the meanest thief I've met in my years as a jurist.' Allen, twenty-nine, had preyed on the aged blind, police charged. He would spot a blind person on the street, follow him home. Gaining entry by posing as a 'board of health doctor,' he would give his victim a fake examination, during which he managed to steal his money. His victims were all over seventy, police said. Allen admitted robbing ten here and working the same racket in fifteen other Pacific Coast cities. He pleaded guilty yesterday to two charges of burglary and one of grand theft. Judge Jacks sentenced him to one to ten years on each charge, to run consecutively." (San Francisco Examiner, June 13, 1940.) (Previous entries, June and July, 1940.)

Plans for immediate construction of another fireproof wing on the newly constructed Hahnemann Hospital, originally scheduled to open on July 1, were announced today.

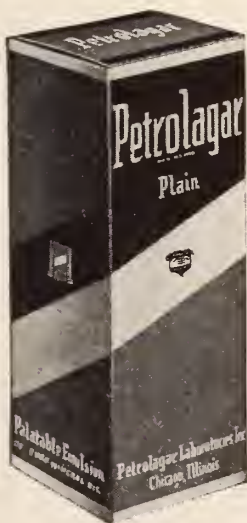
(Continued on Page 30)



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BOARD OF MEDICAL EXAMINERS

(Continued from Page 28)

. . . The hospital is located at California and Maple streets. At a recent meeting the board of directors of the Homeopathic Foundation of California named officers to direct affairs of the hospital. In addition to (Paul) Fleming (secretary and administrator of the institution), they include Marshal Hale, president; Dr. Howard M. Engle, first vice-president; Dr. Franklin H. Cookinham, second vice-president; and R. C. Southworth, treasurer." (San Francisco *Call-Bulletin*, June 8, 1940.)

"Dr. David I. Greenwood, Alhambra chiropractor, today pleaded not guilty to charges of murder and performing a criminal operation before Superior Judge Frank G. Swain. Trial was set for August 2, before Superior Judge Thomas Ambrose. Doctor Greenwood is charged with implication in the death of Miss Verna Marie Hendricks, eighteen. At the preliminary hearing, Miss Hendricks' sister, Ina Ellis Hendricks, testified that she held the light while Doctor Greenwood performed an illegal operation." (Los Angeles *Herald and Express*, July 3, 1940.)

The Shoemaker's Children.—A seven-year study of the nurses in the New York Hospital disclosed that forty-seven cases of tuberculosis have been found among 2,841 graduate nurses and three cases among student nurses. Most of the graduate nurses found to be infected were recent graduates and the report states that for some it was not only their first job, but also their first x-ray.—Elsie Davis, R. N., and Harriet Frost, R. N., *American Journal of Nursing*, April, 1940.

Sulfathiazole Produces the Recovery of Two Patients with Septicemia.—The recovery of two patients from septicemia (bacteria in the blood) was brought about by treatment with sulfathiazole, a new sulfanilamide derivative, Dr. W. Calhoun Stirling, Washington, D. C., reports in *The Journal of the American Medical Association*.

He also used sulfathiazole with success in twenty-five other cases of urinary infections. Many of these infections had not responded to sulfanilamide treatment.

In the author's opinion, sulfathiazole seems less toxic (poisonous) and more effective than other members of the sulfonamide group, nausea being the only side effect seen, and this subsides quickly when the drug is discontinued.

"In sulfanilamide-resistant infections," he says, "sulfathiazole offers a new avenue of attack which in the few cases in which it has been used seems to justify the claims made for it."

Sulfathiazole is absorbed and eliminated quickly, but this is obviated by giving it more often than other sulfanilamide compounds are given.

Syphilis Transmitted by Kissing.—Syphilis was transmitted to five of eleven members of a family by means of kissing, Dr. Gracie R. Rowntree and Dr. James Robert Hendon, Louisville, Kentucky, report in *The Journal of the American Medical Association*. The original familial infection was from an outside source—through kissing.

The authors state that physicians should be more suspicious of all lesions which might possibly be syphilitic. Two of their patients, they say, had previously been to physicians who made a diagnosis of lip impetigo in one and trench mouth in the other. Only good fortune saved the entire family from acquiring the disease, as they are all affectionate people.

HUMAN CALCIUM REQUIREMENTS

● The formation of bone or calcareous tissue is probably the best known use of dietary calcium by the animal body. However, calcium—as the ion or in the form of its compounds—is also concerned with certain other vital physiologic activities, among them normal cardiac function and the normal clotting of blood. The importance of an optimal dietary supply of calcium, therefore, should be immediately apparent. Nevertheless, it appears that many American diets may be deficient in this essential mineral.

Investigations have established within limits the daily needs of humans for calcium (1, 2, 3, 4, 5). By means of balance studies—in which the extent of calcium intake and excretion is closely followed—it has been possible for investigators to arrive at estimates of the daily amounts of this mineral required in various phases of the life cycle. In addition, it has been possible to study the effect of specific factors which may influence calcium utilization, such as vitamin D, phosphates, or certain anions in foods.

As to human daily calcium requirements, some differences apparently exist between the estimates of various authors. However, an allowance of 1.0 gram of calcium per day for children appears well supported by the evidence. For adults, conservative opinion is well expressed in the following quotation (5):

“From the evidence . . . it follows that with the requirement—in the sense of estimate of minimal need with allowance for variations—now put at about 0.75

gram per day for adult maintenance, the women of the population should have an average of about 1 gram per day to provide for the occasional exercise of the functions of pregnancy and lactation without undue tax upon the mother; and that the men of the population should also have an average of about 1 gram of calcium per day, if they are to be nutritionally at their best.”

Protective diet formulation has recently been admirably described (5). The basic pattern of modern diet planning provides that milk—whole or the various forms of canned milk—be included in the ration in such amounts that practically the entire calcium requirement for the individual is supplied from that source alone. Other foods which supply significant amounts of calcium (5) and which normally should be included in the varied diet, serve as supplementary sources of this essential mineral. By this means, the calcium requirement of the individual should be adequately met.

Attention might well be directed to the part which commercially canned foods might play in diet formulation to assure ample calcium intake. Milk in various forms, as well as other foods commonly regarded as valuable sources of calcium, are included among the several hundred available canned foods. The use of these foods according to the modern diet plan should assist materially in providing for an optimal supply of this essential mineral.

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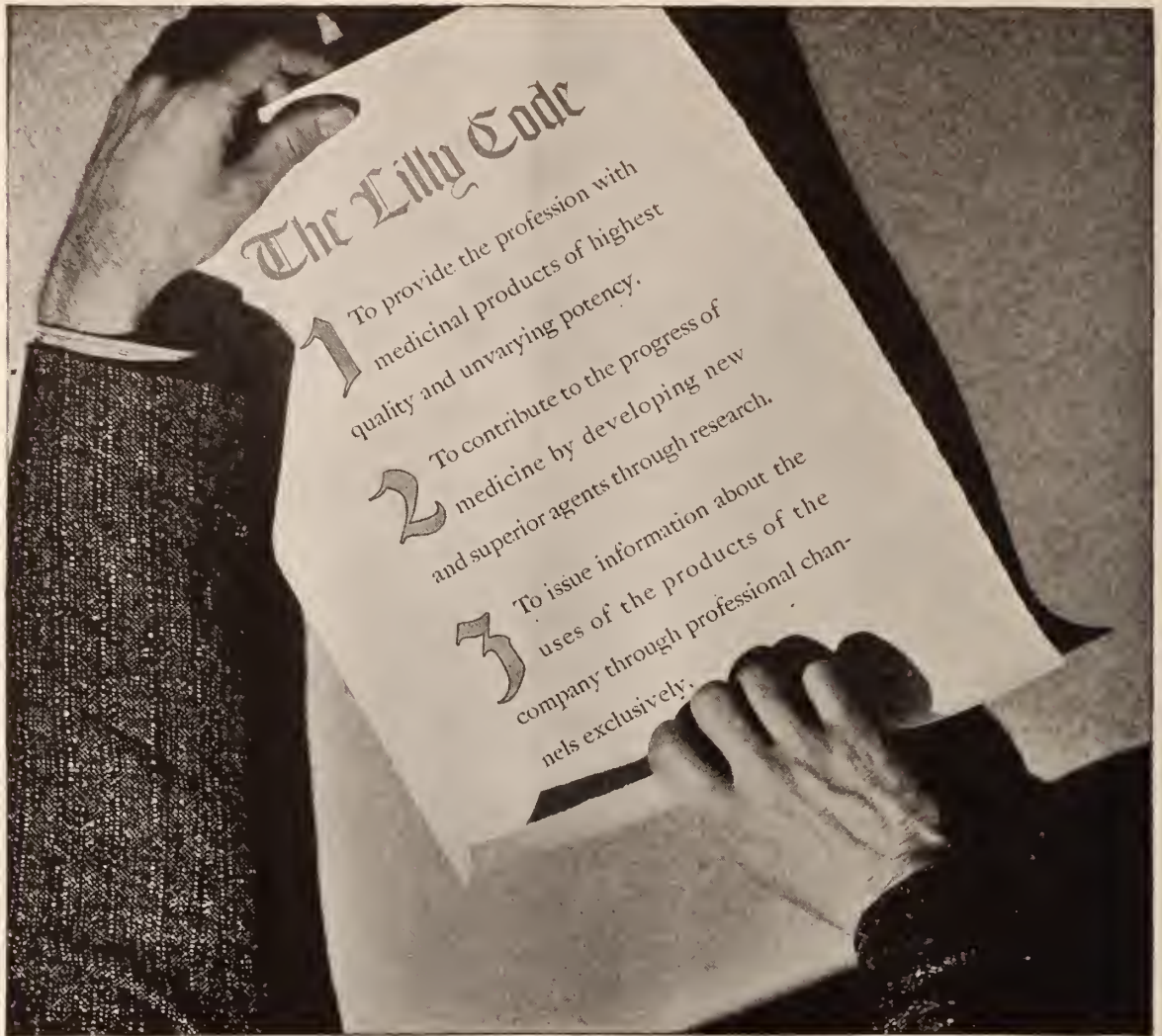
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5. 1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agri., U. S. Government Printing Office, Washington, D. C.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-second in a series, which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



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Committee on Publications

A. A. Alexander	Oakland	1941
Francis E. Toomey	San Diego	1942
G. W. Walker	Fresno	1943
Secretary-Editor, ex officio		

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

MORE CONCERNING MEDICAL MOBILIZATION: COÖPERATION IMPORTANT

Appointment of a National Committee on Medical Preparedness.—At the meeting held on June 29, the Council appointed its chairman, Dr. Philip K. Gilman of San Francisco, to represent the California Medical Association in carrying through plans for medical preparedness now being formulated for the United States. Last month, on page 1 of the OFFICIAL JOURNAL, comment was made on the importance of such proper planning, if the Army, Navy, and aviation forces of our country are to be developed and maintained in highest efficiency.

The American Medical Association on June 11, in annual session at New York, through its House of Delegates, authorized the appointment of a national Committee on Medical Preparedness, consisting of ten elected and five ex-officio members to establish and maintain contact and suitable relationship with all governmental agencies concerned with the prevention of disease and the care of the sick, in both civil and military aspects, so as to make available at the earliest possible moment every facility that the American Medical Association can offer for the health and safety of the American people and the maintenance of American democracy.

Dr. Charles A. Dukes of Oakland, past president of the California Medical Association, was honored by election to this important national committee; and on July 19 he flew to Chicago to attend the organization meeting of the committee and to make a progress report for California.

Doctor Philip K. Gilman, as chairman of the California Committee on Medical Preparedness, in coöperation with the district councilors, has appointed a representative for each of the county medical societies, a list of which appears in this issue (on page 86).

* * *

Questionnaire Blanks Should Be Forwarded at Once.—A questionnaire blank has been sent by the American Medical Association committee to every physician in the United States. The organized medical profession of the United States can only make good its promise of whole-hearted, 100 per cent coöperation with the military and other authorities of the United States if physicians every-

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

where forward to the American Medical Association office, and at an early date, the questionnaire blanks, properly filled in. In requesting such cooperation the national, state, and local Committees on Medical Preparedness seek only to obtain accurate data that will permit the Government to meet to best advantage its military and civil responsibilities in medical care, should certain emergencies arise. Physicians who are tempted to procrastinate or waive these matters aside may well keep in mind that in a real emergency the Government is all-powerful, and that a record of noncoöperation may then be credited with a demerit rather than merit card. Therefore, the California Committee on Medical Preparedness urges members of the California Medical Association to forward the questionnaire blanks as promptly as possible, addressing the same to: American Medical Association Committee on Medical Preparedness, 535 North Dearborn Street, Chicago, Illinois.

* * *

State of California Medical Examining Boards.—Not to be confused with the activities which the American Medical Association is carrying on in efforts to aid the Federal military services, are those being conducted by the Adjutant General of the State of California, in cooperation with the Committee of Fifty appointed by Governor Culbert Olson. Charles A. Dukes, M. D., of Oakland, was honored by appointment on this committee, which has the name "California State Council of Defense."*

In the tentative plan, the State was divided into nineteen districts, each district to have a local medical examining board composed of seven members, as follows: a surgeon; an internist; an eye, ear, nose, and throat specialist; an orthopedist; a neuro-psychiatrist; a radiologist; a dentist.

The district headquarters will be in the following cities, except that San Francisco will have two, and Los Angeles, six districts: Eureka (1); Redding (1); Sacramento (1); Oakland (1); Napa (1); Stockton (1); San Francisco (2); San Jose (1); Fresno (1); Salinas (1); San Diego (1); Los Angeles (district) (6); Riverside (1).

The district councilors of the California Medical Association and the presidents of the county medical societies have been requested to coöperate in the selection of the personnel for the examining boards. The tentative list of counties composing the various districts is given in this issue, on page 87.

"INDEMNITY DEFENSE FUND" OF THE CALIFORNIA MEDICAL ASSOCIATION

Origin of the California Indemnity Defense Fund.—Some twenty-four years ago, on May 20, 1916, the Council of the California Medical Association adopted a resolution whereby "a separate fund, to be known as an 'Indemnity Malpractice Fund,'" came into being, intended to provide, as one of its purposes, "the payment of malpractice indemnity judgments and settlements"; the fund "to be raised through voluntary assessment of \$15 yearly for at least two years," and "to give indemnity protection to only those who enter

therein." In accordance therewith, rules and regulations covering the administration of the "Indemnity Defense Fund of the Contributing Members of the Medical Society of the State of California" (the name at that time of the California Medical Association) were adopted; three trustees—Lemuel P. Adams of Oakland, the late A. S. Lobingier of Los Angeles, and the late William Ellery Briggs of Sacramento—being elected to carry on the work. Other trustees included the late Rea Smith of Los Angeles, the late William Duffield of Los Angeles, Howard Morrow of San Francisco, J. B. Harris of Sacramento, and Karl L. Schaupp of San Francisco. Dr. Lemuel P. Adams has been a trustee from the beginning.

* * *

Discontinuance of the Organization.—The Fund carried on its work for several years, but an increasing number of malpractice suits (the first wave of what might be termed the existing malpractice sport engaged in by certain persons) led the House of Delegates of the California Medical Association, on June 23, 1923, to pass "a resolution, unanimously adopted: *Resolved*, That the Indemnity Defense Fund be discontinued" . . . ; with a further provision that each member of the Fund be notified. The action taken was printed in the *California State Journal of Medicine* (former name of CALIFORNIA AND WESTERN MEDICINE) in the issue of August, 1923 (on pages 344, 351, 434, and 484).

On June 30, 1924, the other legal protection carried on at that time by the State Medical Association, known as "optional" medical defense (which came into existence on May 17, 1922, to take the place of prior medical defense maintained by the State Association), was likewise terminated.

The physicians who voluntarily joined the Indemnity Defense Fund received, for the money paid by them, a comparatively large return of protection—at least when judged by the cost of present-day malpractice defense premiums. The majority of members in 1931 assigned their residual interests in the Fund to the nonprofit corporation, the "Trustees Of The California Medical Association," which body, by recent action of the Council, has assumed custodial care of the Indemnity Defense Fund.

* * *

Proposed Termination of the Fund.—In order to be in position to terminate the Indemnity Defense Fund, the Council last year authorized the purchase of a certificate of insurance from Lloyd's of London for a period of five years, from January 15, 1940; and on June 29 last, the Council further ratified procedures for the proper distribution of the Fund, in which at the present time the nonprofit corporation, or holding company of the California Medical Association, the "Trustees Of The California Medical Association," has the major interest. These comments are made, not only for the information of present members of the State Association, but particularly for those of the Indemnity Defense Fund who, in 1931, failed to assign their respective interests, and who will shortly receive further information on the subject.

* Additional comment on page 87.

MEDICAL EXHIBITS AT GOLDEN GATE EXPOSITION: HERZSTEIN BEQUEST

How the Herzstein Bequest Has Been of Aid. When the Golden Gate International Exposition opened its doors last year, one of the most interesting exhibits there displayed was that devised by the Cancer Commission of the California Medical Association, and located in the Science Building. Its cost and maintenance were covered by income from a bequest to the Association, made by the late Morris Herzstein of San Francisco, whose death occurred on October 27, 1927, and whose will contained the following provision:*

"First, I give to the Union Trust Company, a Corporation doing business in the city of San Francisco, State of California, the sum of Twenty thousand dollars (\$20,000), but in trust to hold and invest in first-class nontaxable securities and to yearly pay the net income from said securities to the State Medical Society of California, to be used only by this Society in taking such steps as the Society may consider best for the suppression of quackery in the practice of medicine within the State of California."

When the Fair was again opened this year, the Cancer Exhibit was reinstalled. Recently, educational literature concerning cancer has also been made available in the booth; so that citizens who visit the exhibit are now able to carry away printed reminders of the information delineated in the exhibit charts.

During the last month an equally interesting and very attractive exhibit, entitled "The Human Eye," and sponsored by physicians and associated optical groups of the Bay region, has been placed in the Science Building. For additional information concerning this display, readers are referred to the illustrated description to be found in this issue of CALIFORNIA AND WESTERN MEDICINE (page 91).

Mention should be made also of the excellent medical exhibits of the University of California, of the Pacific Coast Roentgen Society, the California Tuberculosis Association, the California State Board of Public Health, the Western Urological Association, and other organizations.

* * *

Medical Exhibits Should Be Salvaged for Future Use at California State and County Fairs.—Such is the high quality of these exhibits that it is to be hoped that it may be possible to salvage at least a portion of them for future continued use in the state and county fairs of California; especially since there exist few superior agencies for the dissemination of medical facts to the public than the many fairs annually held in California. The State Fair at Sacramento and the Los Angeles County Fair at Pomona, each have an annual attendance of about 500,000 persons, and fairs of other counties are attended by keenly observing persons in proportion. In this connection note may be made concerning the efforts of the Western Branch of the American Public Health Association through a committee of which Guy S. Millberry, D.D.S., is chairman, to develop a plan

for a public health museum building to be erected in San Francisco.

Why not avail ourselves, then, of these excellent opportunities for public health education? With a moderate expenditure of funds, many of the medical-exhibit panels in the Science Building at Treasure Island in San Francisco could be made of inestimable service for years to come. What worthier use, indeed, of Herzstein Bequest funds could be presented than in salvaging some of the above exhibits for such an objective?

PLANS FOR 1941 ANNUAL SESSION AT DEL MONTE

Coöperation of Essayists and Others Requested.—Because events follow in such rapid sequence, it may be in order to remind members of the California Medical Association that those who would take part in the annual session of next year, to be held at Hotel Del Monte, May 5–8 inclusive (Monday–Thursday), may well begin the formulation of their plans now.

Prospective essayists, in particular, should communicate with the secretary of the scientific section before which it is desired to present a paper. The roster of section officers appears in each issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 6. Or, if a scientific exhibit is contemplated, these summer months may offer special opportunities for needed preparation.

* * *

Council Approves Reallocation of Meeting Arrangements.—It should be of interest to members that the recommendations of the California Medical Association Committee on Scientific Work, regarding basic arrangements in program allocations, have been approved by the Council. In accordance therewith, at Del Monte in 1941, the morning meetings will be given over to general sessions, and the allocation for Tuesday afternoon entertainment will be discontinued, thus permitting scientific sections to hold meetings on each of the four afternoons. Medical and surgical films will be presented in one of the larger meeting rooms during the mornings, according to scheduled announcements, so that members who wish to see certain films may arrange their program. Owing to the limited number of rooms available for meetings, the Council has announced that it will be necessary for all affiliated societies and activities to hold their meetings on the Saturday and Sunday preceding the annual session, or on the Thursday afternoon of the session.

The management of the Hotel Del Monte contemplate certain construction changes that should aid greatly in making this meeting place more popular than ever to the members of the California Medical Association, and it is to be hoped these improvements will be made. Reservations will be in charge of the Hotel Del Monte, and inquiries or requests for the same should be sent to Hotel Del Monte, Del Monte, California.

* Excerpt from will of Morris Herzstein, Superior Court Case 48,446.

ENACTMENT OF CALIFORNIA LAWS THROUGH INITIATIVE PETITION

Recital of Past Experiences with Legislation on Medical and Public Health Measures.—Enactment of statutes by vote of the electorate is nothing new to physician-citizens of California, because, since the adoption of the constitutional amendment that brought the California initiative and referendum into being at the state election of October 10, 1911, organized medicine has found it necessary, in its efforts to protect the public health, to give hard battle on a number of proposed laws related to medical and public health functions.

Thus, at the state election of 1920 a proposed "constitutional amendment" that would have "prohibited compulsory vaccination" was defeated by a vote of 468,000 to 359,000.*

Concerning "statutes" submitted through initiative petitions, a proposed law "to license drugless physicians," and placed on the ballot in 1914, three years after the adoption of the initiative in California, went down to defeat by a vote of 462,000 against, to 223,000 for.

In 1920, an effort "to create a board of chiropractic examiners" was lost, the vote being 402,000 against, and 390,000 for the measure.

However, two years later, in 1922, a different story was recorded, for then the osteopathic and chiropractic groups joined forces, each submitting a separate act, and each coming out victorious. The total vote "to create a board of chiropractic examiners" was 481,000 in favor, and the against votes numbered 327,000; while "to create a board of osteopathic examiners" the total vote in favor was 439,000, and the ballots against totaled 327,000. But in 1934, when the chiropractors sought to "amend" their frozen law, the vote "against" was 1,082,000, with 662,000 ballots in favor. And in 1939 the second attempt to "amend" was likewise lost, this time on a vote of 801,000 in favor, with 1,895,000 votes against.

Also, in the year 1934, the naturopathic group sought an initiative "to license naturopaths"; the ballots in favor numbering 492,000, with 1,115,000 votes against.

Three efforts have been made by antivivisection proponents to secure the enactment of statutes through initiative action, as follows:

<i>Year</i>	<i>Vote (in favor)</i>	<i>Vote (against)</i>
1920	272,000	527,000
1922	226,000	514,000
1938	721,000	1,581,000

When the next attempt will be made to use California as an antivivisection guinea pig is not known, but it is quite probable that, in good time, another effort to have such a law passed will become manifest, since the proponents of that measure seem amply supplied with funds.

The illuminating figures, given above, should bring back to physicians who took part in the various battles a host of remembrances. The further fact that so many measures related to public health

interests have been proposed for enactment through initiative vote of the electorate, combined with the heavy expenditures initiative voting involves, should make the subject of more than ordinary interest to both medical men and women and other citizens.

* * *

Important Items in Initiative Procedures.—

It must not be forgotten that the number of signatures required to validate an initiative petition is variable, being a percentage of the total votes cast for a governor at the last prior gubernatorial election. At the present time a total of 212,000 valid signatures is required.

The "signatures may be solicited for a petition by any qualified elector of the county in which the petition is circulated. The person obtaining signatures is required to make an affidavit 'stating his own qualifications, and that the signatures to the attached section (of the petition) were made in his presence, and to the best of his knowledge and belief each signature to the section is the genuine signature of the person whose name it appears to be.'"

It is important to remember that the date and address following the signature must be in the same handwriting. Experience has shown that it is usually necessary "to obtain at least one-third more signatures than the minimum so as to allow for errors and challenges of the validity of the signatures." Signature solicitors usually charge ten cents or more per name.

Any organization raising or spending more than \$1,000 in a campaign on measures submitted to the people through initiative must file a report through the Secretary of State.

* * *

Basic Science Law Must Not Be "Frozen."—

Note may be made that the phraseology of the chiropractic statute, enacted through initiative in 1922, makes it a "frozen" law; that is, the statute can only be amended through another initiative vote. The osteopathic law of the same year is not frozen, because it contains a provision whereby changes may be made through amendments by the California Legislature to the Medical Practice Act of the state! In this connection, the following may be kept in mind:

The constitutional provision that initiative acts may be amended or repealed only by vote of the people gives the acts approved in this way special protections which make them something akin to constitutional amendments in effect.

Nevertheless, the Constitution also makes it possible to include in the Act a provision allowing amendment by the Legislature. Sponsors of several initiatives have taken advantage of this opportunity to allow for flexibility in the statute.

These comments are presented because there has been so much discussion in recent years concerning the submittal of a basic science law through initiative petition. If such a measure is submitted, it may be well to provide for possible modification in the future, through inclusion of a provision for amendments by action of the California Legislature, using the Medical Practice Act as the means to prevent a frozen basic science law.

* Figures given in these comments are correct as to thousands.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 86.

EDITORIAL COMMENT†

ANTITOXIN ACTION OF IRON SALTS

The success of iron in the treatment of certain types of anemia has stimulated the hope that iron salts might be equally effective in increasing the normal resistance to bacterial infections. That this hope may eventually be realized is currently alleged by Hettche¹ of the Hygienic Institute, University of Munich, who found that, with proper subcutaneous doses of iron-manganese mixtures, laboratory animals may be rendered refractory to multiple lethal doses of at least three specific bacterial toxins.

The first definite immunological success of iron therapy was reported about three years ago by Wohlfeil,² of the Robert Koch Institute, Berlin. He found that subcutaneous injections of ferro-ammonium-sulphate often protect guinea pigs against minimal lethal doses of diphtheria toxin, and that this protective action can be increased by the simultaneous injection of magnesium or copper salts, which he pictured acting as iron "activators."

Hettche, and his coworkers,³ have not only confirmed this finding, but have extended the tests to include other animal species and to other bacterial toxins. They find that iron therapy has prophylactic or antitoxic value if given parenterally, but is without antitoxic action if given by mouth. They emphasize the fact that optimum doses must be used, excessive doses being relatively ineffective. In their hands local toxic reactions may be reduced by selecting ascorbic acid salts of iron, *e. g.*, "ceferro." A mixture of "ceferro" and $MnSO_4$ allegedly has not only a prophylactic action against diphtheria, tetanus and botulinus toxins, but is also therapeutically effective, protecting laboratory animals against previous injections of multilethal doses of these toxins.

The German hygienists do not suggest the substitution of parenteral iron therapy for present methods of specific treatment or prophylaxis. They are of the opinion, however, that it will be found to be a valuable adjunct to such methods. Theoretically, the reported antitoxic action of iron salts is explained on the assumption that "activated" iron increases the respiratory enzymes in reticulo-endothelial cells, and in other cells responsible for specific antitoxin production.

Parenteral administration of iron is not viewed with favor by most American pharmacologists. Injection of small amounts of iron salts is very painful, and therapeutically ineffective in iron deficiency anemias; and larger doses produce severe toxic reactions. The assertion that "ceferro" is relatively nontoxic needs confirmation. The hypothetical increase in reticulo-endothelial enzymes would be of basic theoretical interest, if supported by adequate chemical evidence.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

BETTER CLINICAL RESULTS WITH THE SULFONAMIDE PREPARATIONS IN GONORRHEAL URETHRITIS

This article is primarily written for the purpose of decreasing the number of failures caused by sulfanilamide, and its related compounds, in the treatment of gonorrheal male urethritis.

When, how, and why to use a certain preparation of sulfanilamide is very important toward establishing a cure for gonococcal infections. Naturally, our first thought would be to choose a drug whose toxicity is so low and its therapeutic index so high that the patient can tolerate a complete course of treatment orally without any alarming systemic effects.

Consequently, the ideal chemotherapeutic agent would be one which can reduce the amount of urethral discharge, give a negative smear, and produce a clear urine in the first and second glass test. Should this particular chosen drug produce mild toxic systemic reactions, although it has benefited the local condition, the dose should be decreased to meet the patient's tolerance. If a physical breakdown occurs due to a serious complication, such as hemolytic anemia, agranulocytosis, or acute hepatitis, stop the drug immediately and depend entirely upon local treatment for a cure. Likewise, if a drug can be well tolerated systemically, and there is no improvement at the site of infection, the drug is useless and should be discontinued in favor of local treatment.

To be more specific, if a patient does not respond after one week's oral treatment with sulfanilamide, spare the patient's pocketbook and protect his defensive mechanism by discontinuing the drug. Use local treatment, as a mild silver protein preparation, for about two weeks and then resume oral treatment with a different brand of sulfonamide, as neoprontosil, sulfapyridine, uliron sodium, etc.

Usually the patient will respond to some degree on such a régime; should he not, however, show any improvement to a second course of a different oral preparation, begin to build up the patient's resistance to the gonococcus. This can be accomplished by mild local treatment and general systemic improvement with the vitamins, liver and iron preparations, good nutritious food, bland diet, and avoidance of extreme physical exertion.

In conclusion, one must bear in mind that even a procedure such as is outlined above will in some cases produce no results. Consequently, we must

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Hettche, H. O., *Zeitschr. f. Immunitätsforsch.*, 97:81, (Nov.), 1939.

² Wohlfeil, T., *Zentralb. f. Bakt.*, 139:27, 1937.

³ Hettche, H. O., and Strassburger, H., *Zeitschr. f. Immunitätsforsch.*, 97:109, (Dec.) 1939.

employ anteroposterior urethroscopy for foci of infections involving the urethral follicles and crypts, prostatic ducts, strictures, seminal vesicals and the prostate. Should such a method of examination fail to establish a cure, our last and final resort is hyperpyrexia.

The tests* to determine the curability of gonorrheal urethritis are the passage of a sound, prostatic massage, centrifuged morning specimen of urine, the complement-fixation test, and culture.

The importance of this system of treatment will be stressed in a paper to be published at a future date, comprising the results of two hundred cases of of acute gonorrheal urethritis treated with sulfanilamide, neoprontosil, sulfapyridine, and uliron sodium.

453 Flood Building.

HERMAN FEINBERG,
San Francisco.

POTENTIATED PAN-INFLUENZA VACCINE

Horsfall and Lennette,¹ of the International Health Laboratories, New York, report the discovery of a "duplex" vaccine equally effective against all types of influenza virus. The new synergic vaccine is a basic challenge to immunologic theorists, and may eventually lead to effective clinical mastery of this disease.

During the course of certain experiments, four presumably normal ferrets were inoculated intranasally by the New York investigators with multiple doses of their 1939 strain of the influenza virus. All four developed typical symptoms of experimental influenza. During convalescence, however, they began to manifest evidence of a secondary, distemper-like infection, from which one died and the remaining three were killed on the eleventh day. To prevent the possible spread of the epizootic to the normal ferret colony, a formalized vaccine was prepared from the lungs and spleens of these four animals and two cubic centimeters of the 1:1000 formaldehyd extract injected subcutaneously into each of the 157 normal ferrets. Such formalized vaccines had been found effective in preventing the spread of distemper on previous occasions.

Two days after giving this formalized vaccine, three groups of vaccinated normal ferrets were inoculated intranasally with 1,000 infectious units of three antigenically different² strains of the influenza virus. To their surprise none of these vaccinated ferrets developed influenza. Serum drawn from control vaccinated ferrets neutralized all three strains of influenza virus in high dilution. (Ferret serum is normally nonvirucidal.) These findings suggested that the formalized distemper vaccine had, in some wholly unexpected way, actively immunized the ferrets against at least three antigenically different strains of the influenza virus. At the same time the vaccine had rendered the ferrets relatively immune to canine distemper.

In order to reproduce this pan-immunizing vaccine, formalized vaccines were prepared from normal ferrets infected with influenza virus, or with distemper virus. The two vaccines, mixed *in vitro*, failed to stimulate the development of an active influenza immunity. In a second attempt, ferrets were inoculated simultaneously with influenza and distemper virus, and formalized vaccines prepared from their doubly infected lungs and spleens. Most of the duplex vaccines thus prepared proved to be ineffective. By varying the dosage and time interval between injections, however, a number of fairly effective synergic vaccines were eventually prepared. Because of the number of variables in the production of such synergic vaccines, much more work will have to be done before successful "binomial" vaccines can be regularly reproduced.

No theory of virus or antigenic potentiation has thus far been suggested by the New York investigators to account for their observed results. The work is of basic clinical interest, however, since it suggests that an effective pan-immunizing influenza vaccine is theoretically possible. If this hope is realized, the observations of Horsfall and Lennette may eventually be recorded as the most important basic medical discovery of the present generation.

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W. H. MANWARING,
Stanford University.

DEATH FROM SULFANILAMIDE: A CALIFORNIA COURT DECISION

Physicians and a clinic were absolved from liability for a death due to sulfanilamide, and a precedent was established by a medical legal opinion given on January 10, 1940 by Superior Court Judge Clement L. Shinn in Los Angeles.

A white male patient, suffering from an acute specific infection, was treated with sulfanilamide at a venereal disease clinic for a period of five weeks. Subsequently he developed complications from the use of the drug and died. A malpractice suit was instituted against the physicians and the clinic, and following is the opinion of the Court:

This young man was being given a dangerous drug. He was not being treated for a consideration; he was being treated for his own good by an experienced doctor—a man who appears to me to be a competent and conscientious man. There are, of course, recognized and unavoidable dangers in certain types of treatment, and physicians as a rule do their utmost to minimize these dangers. The medical profession has to progress, not for its own good, but for the good of humanity, and types of treatment which are efficacious cannot be abandoned because they are not utterly safe. Accidents will happen. Here was a young man who fell in that indeterminable class who cannot tolerate or handle this drug in considerable quantities. It does not appear that there was any way for the medical profession to tell who could or could not handle the drug except by using it and watching the results; and when they tried it out on this patient they were not doing wrong by him. If they had been successful, it would have changed his entire life. He certainly was leading a miserable existence the way it was. He had had other treatment. It may be that this remedy was the only one that would have reached his case. We don't know about that. He did what appeared to be the right thing in going to the clinic and submitting to the treatment. The drug was not given in excessive quantities. The young man was given printed

* Feinberg, Herman: Tests to Determine the Curability of Gonorrheal Urethritis, Calif. and West. Med., 46:6 (Jan.), 1937.

¹ Horsfall, Frank L., Jr., and Lennette, Edwin H., Science, 71:492, (May 2), 1940.

² Horsfall, Frank L., Jr., and Lennette, Edwin H., J. Bact., 39:56, 1940.

instructions, advising him to watch for certain enumerated manifestations of ill effects. These instructions had been carefully prepared by competent authorities, and listed the unfavorable reactions that were known at that time. He was instructed to report to the doctor immediately upon the discovery of any of these symptoms, and he was an intelligent young man. Once a week he was examined, and tests which were generally used by the profession at that time were made. No evidence of unfavorable reaction occurred until the end of the fifth week, at which time the treatment was stopped. It appears from the evidence that the treatment was administered scientifically and carefully, and that the results which followed could not have been anticipated. The treatment was proper under all of the circumstances. The unfortunate consequence was not the result of negligence.

Judgment will be for the defendants.
State Building.

MALCOLM H. MERRILL,
San Francisco.

Knowledge of disease has now advanced so far that it is very often desirable to treat the patient before he knows that he is sick. People stricken with acute disease hasten to their doctor for aid. Those suffering from a chronic disease of insidious onset tend to put off their visit to a doctor and to seek relief by self-treatment. Yet we know that, in many diseases, the best hope for cure depends on early treatment, treatment even before the symptoms appear. This is not only true of tuberculosis, but of several other diseases, including the two at the top of the list of causes of death, cancer and heart disease. It is true of diabetes, of many cases of syphilis, and of certain kidney diseases which though so slight as to be overlooked may cause high blood pressure later on. An attempt has been made by the American Medical Association to adjust the private practice of medicine to this situation, but periodic medical examinations have not been widely accepted.—J. Rosslyn Earp, M. D., *Health News*, May, 1940.

Two American Physicians Are Honored by Special Postage Stamp Issue.—The benevolent character of the service which physicians give to suffering humanity is typified by the general practitioner of medicine and the army medical officer thus memorialized, *The Journal of the American Medical Association* says, in commenting on an announcement by the Post Office Department that the late Major Walter Reed, M. D., of the Army Medical Corps, and Crawford W. Long, M. D., of Georgia, will be among those honored in a famous American series of postage stamps to be issued soon.

"Although other names might well have been added to this brief list, no one will deny that the two selected fully merit this honor," *The Journal* says. "Our Eastern shores and many of our cities were invaded some ninety-five times by yellow fever before Doctors Reed, Carroll, Agramonte, and Lazear conducted experiments in Cuba which demonstrated that yellow fever is transmitted by the bites of certain species of mosquitoes. Yellow fever had been present in the Western Hemisphere for at least three hundred years and had caused tens of thousands of deaths. Following this discovery by Walter Reed and his associates in 1900, yellow fever soon disappeared from North America and has never returned. Dr. Crawford W. Long, a general practitioner of medicine, on March 30, 1842, first used sulfuric ether as an anesthetic during the performance of a surgical operation. Doctor Long performed this operation on James M. Venable in Jefferson, Jackson County, Georgia, a small town then many miles from a railroad."

The Journal called attention last year to the disparity between the number of physicians in other countries who had been honored by special issues of postage stamps and the number so honored in the United States.

ORIGINAL ARTICLES

GAS CHANGES IN MATERNAL AND FETAL BLOOD DURING CYCLOPROPANE OBSTETRIC ANESTHESIA*

By E. A. ROVENSTINE, M. D.

JOHN ADRIANI, M. D.

AND

W. E. STUDDIFORD, M. D.

New York, N. Y.

MORE than ninety-three years have passed since the first obstetric anesthesia. During all of this time there has been a constant search for the ideal anesthetic, or analgesic drug, to relieve pain associated with childbirth. The lack of agreement in the voluminous literature that has been accumulated on the subject is evidence that the search must go on.

In nearly a century of experimenting, many drugs have been recommended enthusiastically and many unwarranted claims have been made, but no drug is definitely established today as being superior to all others. In fact, it is not unreasonable to cast considerable doubt on any claim that there is a safer drug available than ether, which Simpson gave during the first obstetric delivery with anesthesia.

Other surgical procedures have been more fortunate in so far as efforts to improve anesthesia for their more satisfactory and convenient completion are concerned. But it is not strange that obstetric anesthesia has not kept pace with other advances in the specialty. The obstetrical patient presents certain problems that are apart from those of surgery in general. Firstly, there are the lives of two individuals to be considered when anesthetic drugs are administered during childbirth. This, in itself, would not be greatly significant were it not true that in one of them the physiological relationships are not only decidedly different, but are poorly defined. Secondly, the physiology of the pregnant uterus is readily influenced by drugs administered to relieve the pains associated with its contractions. Thirdly, physiological variations from the normal female are always encountered to complicate the whole procedure.

When maternal welfare is placed above that of a nonviable fetus, no more perplexing problems are presented than are regularly encountered with surgical anesthesia. Fortunately, these cases are rare. Most often the efforts at maternal pain relief must be made with the more important consideration of delivering an uninjured fetus.

All drugs producing analgesia or anesthesia must, in some way, alter or interrupt the processes of cell metabolism. This alteration, if carried out to a certain degree, results in irreversible cell activity. Therefore, no drug for this purpose falls without the classification of a protoplasmic poison.

* Read before the joint meeting of the sections on Anesthesiology and Obstetrics and Gynecology of the California Medical Association at the sixty-ninth annual session, Coronado, May 6-9, 1940.

From the Division of Surgery, Departments of Anesthesia, and Obstetrics and Gynecology, New York University College of Medicine, New York, N. Y.

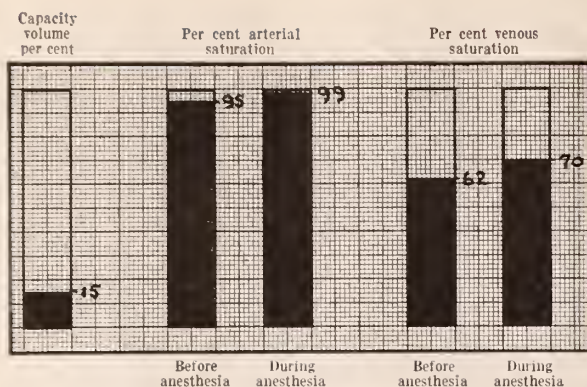


Fig. 1.—Maternal blood oxygen.

Drug poisoning is, of course, both quantitative and qualitative, depending upon the drug and the cell. Drugs given to pregnant women are being exposed to two types of cells: the maternal, which may react in one way, and the fetal, which may react differently. At the present time there is considerable speculation in explaining drug action on the maternal cell. There is scarcely enough evidence even to speculate on the action of drugs on the cells of the fetus.

New drugs and new methods, as they are introduced for obstetric anesthesia, gain popularity with certain individuals. Others may use them for want of something better or because of their convenience. No new drugs are employed because their pharmacological action is established as being safer or more desirable for both mother and fetus. The laboratory studies that might establish these criteria are not easily completed. The clinical observations, to which the final appeal must be made for any drug, lend themselves more readily to forming impressions than to accurate interpretations.

CYCLOPROPANE

Cyclopropane is one of the more recent drugs recommended for obstetric anesthesia. It was to be expected that this gas would be received enthusiastically, since it has many properties which suggest it might overcome certain objections to other agents in use. The potency of this gas was among the most important of these properties. Its administration may be carried out with very high oxygen dilution. Since no cause of neonatal death has been stressed more than asphyxia, the high oxygen in cyclopropane mixtures seemed very desirable. It has been determined that the fetus *in utero* is in a state of asphyxia. Whereas the arterial blood of the normal adult is saturated to about 95 per cent of its capacity, that of the fetus is often not more than half as well saturated. The fetus is also in a state of acidosis, with a high carbon dioxide tension in its blood.¹ Moreover, these biochemical differences from the adult are exaggerated in infants with asphyxia neonatorum. They are also augmented by anesthesia associated with low oxygen tensions, as is had with nitrous oxid-oxygen mixtures. These facts have made oxygen an urgent necessity in the prevention and treatment of fetal asphyxia. It was the logical inference that a small amount of cyclopropane, mixed with much oxygen,

would eliminate the danger of reducing the fetal blood oxygen during anesthesia.

The first clinical report of the use of cyclopropane in obstetrics was conservative in its claims, since it was realized that many experiments, long clinical trial, and much statistical data must accumulate to establish the merits of any drug.² A more generous endorsement followed the widespread use of cyclopropane throughout the country. However, cyclopropane has about passed through the early wave of enthusiasm, and it may be said to be now in the stage of critical evaluation and experimental investigation. Its proper place, however, in obstetrical anesthesia is yet to be determined. Years of accumulated information may be needed to establish that place.

There is considerable clinical and laboratory evidence accumulated to guide in the proper use of cyclopropane for the mother. It may be expected, in competent hands, to produce anesthesia even in the unpremedicated patient, rapidly and pleasantly when concentrations as low as 15 per cent are administered. The presence of respiratory infections need not give alarming concern, since their severity probably will not be increased with cyclopropane. The gas undergoes no change in the body and is eliminated almost entirely by the lungs. After a few minutes of anesthesia, the venous blood concentration of cyclopropane approaches the arterial. This average figure is 15 milligrams per 100 cubic centimeters during second-plane anesthesia. Complete body saturation does not occur at this time, but requires two or more hours. Desaturation requires a similar time, and most of the agent is eliminated in less than ten minutes with but traces in the blood for two hours. The rapid elimination permits rapid recovery and the return of normal reflex activity. The incidence of vomiting during cyclopropane anesthesia induction is less than with volatile agents. The gas does not stimulate respirations and respiratory arrest precedes circulatory paralysis. The effects of the drug upon the circulatory system are the subject of an important controversy. Cardiac arrhythmias are not uncommon and their etiologic mechanism is not established.

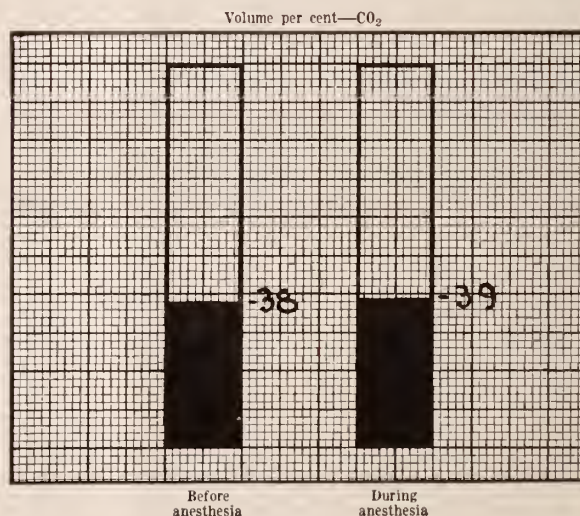


Fig. 2.—Maternal blood.

However, patients without serious pre-anesthetic arrhythmias need not be expected to develop them during cyclopropane anesthesia.

The effects of cyclopropane upon the liver of the pregnant woman are interesting, since even in the presence of toxemia the excretion of dyes used for liver function tests is unchanged by cyclopropane. Cyclopropane, in contradistinction to other inhalation anesthetic agents, does not alter the acid-base balance or decrease the p^H of the blood. The total base, the nonprotein nitrogen, the sugar and combining power of the blood are not changed by cyclopropane in the normal pregnant woman.

The effects of the drug upon the uterus have been carefully studied.³ The frequency and duration of uterine contractions are not affected by cyclopropane. The strength of contractions which are markedly reduced with ether and chloroform are unaffected by cyclopropane. The contribution of the abdominal muscles to the intra-uterine pressure is reduced with the gas or any other narcotic drug. The effective arterial pressure which irrigates the placenta is increased with cyclopropane, and other anesthetics. Clinical observations have suggested that light cyclopropane increases uterine tone, and that even though tone is decreased with deep anesthesia the uterus contracts rapidly and strongly during recovery.

The effects of cyclopropane upon the fetus cannot be set down with confidence. Laboratory studies are scarce, incomplete and difficult of interpretation. It is established that cyclopropane, like other narcotics and hypnotics, passes from the maternal to the fetal circulation. The changes from normal blood gas tensions that occur have been reported by Smith⁴ and studied here.

EXPERIMENTAL METHOD

The initial problem that required solution in this study was the selection of a convenient method for collecting blood samples containing cyclopropane. Because of the marked solubility of the gas in oil, the familiar methods could not be used. A simple syringe method of collecting blood anaerobically and storing it over mercury was devised by one of us (J. A.).⁵ This method was later adopted and used by Smith⁴ to carry out his work with cyclopropane.

All available types of obstetrical cases were studied. No pre-anesthetic medication was given.

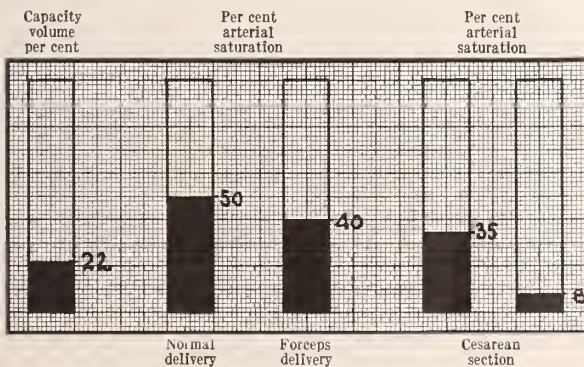


Fig. 3.—Fetal blood oxygen.

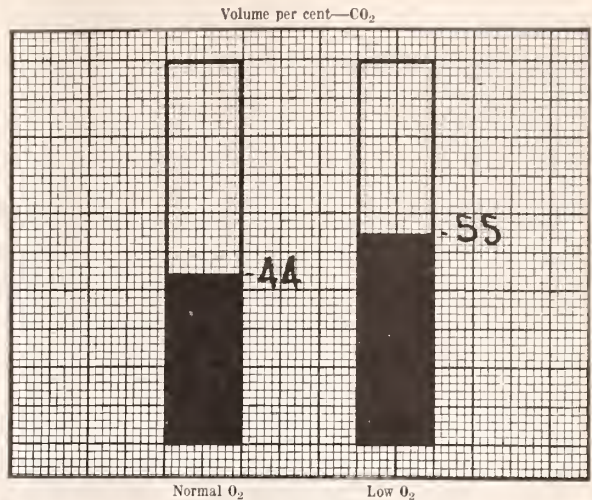


Fig. 4.—Fetal blood.

Anesthesia was administered by physicians specializing in anesthesia. The closed or carbon dioxide absorption technique was utilized. Induction was accomplished with the carbon dioxide absorber in use. A mixture of 25 per cent cyclopropane and 75 per cent oxygen was first administered. After anesthesia was established it was maintained in the second plane of the third stage. A pharyngeal airway was inserted when required. Before anesthesia was induced, a specimen of maternal blood was collected from the radial or brachial artery, or in some cases from an arm vein. Immediately after delivery two Kocher clamps were placed about two inches apart close to the baby. Simultaneously another pair were placed close to the vulva. By cutting between them, a segment of cord was obtained. Blood from the infant was always taken before the onset of respirations. Enough arterial blood was removed from the umbilical vein to permit analysis for total carbon dioxide, oxygen, and cyclopropane. At approximately the moment the cord was clamped another maternal arm specimen was obtained. At cesarean section a segment of cord was obtained as soon as the uterus was incised in the same manner as during normal deliveries. The blood was analyzed as soon as possible after collection. The total carbon dioxide and oxygen contents were determined by the standard technique on the constant volume manometric apparatus of Van Slyke and Niell. Cyclopropane was determined on the manometer by the method described by Orcutt and Waters.⁶ The oxygen capacity was determined by aerating 3 to 4 cubic centimeters of blood for fifteen minutes in a separatory funnel rotated at a high speed, and determining the total oxygen by the manometric method.

RESULTS

The cases studied include normal deliveries (6), forceps deliveries (12), and cesarean sections (18). The oxygen capacity of the maternal blood was found to be approximately the same in all patients, averaging 15 volumes per cent. The total carbon dioxide of the maternal arterial blood averaged 38 volumes per cent. There was an increase of 1 to 2 volumes per cent carbon dioxide in some patients,

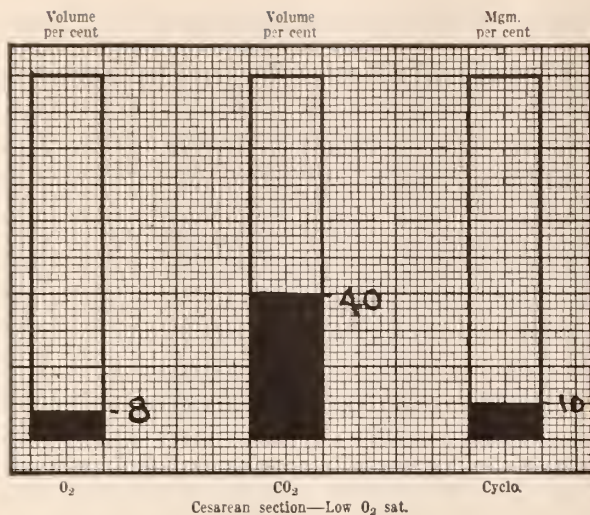


Fig. 5.—Fetal blood.

and a decrease of about one volume per cent in others during anesthesia.

The oxygen content of the venous blood varied widely (20 to 80 per cent saturation) before anesthesia. During anesthesia the venous blood oxygen saturation was always raised. The average for the series was 65 per cent saturation before and 70 per cent during anesthesia. The venous blood oxygen approached nearer the figure for arterial saturation in the cases with more prolonged anesthesia. It has been noted before that the difference in oxygen saturation of arterial and venous blood was less during cyclopropane than with other anesthetic mixtures. Although this phenomena has been explained on the basis of the high oxygen concentration given, it is quite likely that the action of cyclopropane is largely responsible. The gas may have an effect upon the contractile mechanism of capillaries. This same effect may account for the increased bleeding or oozing from cut surfaces that is often associated with cyclopropane anesthesia.

The oxygen content of the arterial blood of the mothers averaged 95 per cent saturation before anesthesia. There was a constant increase to 99

or 100 per cent saturation in all patients during anesthesia.

The oxygen capacity of the fetal blood was higher than the maternal. For all the cases it averaged 22 volumes per cent. This difference may be explained, partially at least, on the basis of the difference between maternal and fetal hemoglobin. The oxygen content of the fetal arterial blood varied with the type of delivery. In normal deliveries, the average was 11 volumes per cent or approximately 50 per cent saturation. This is slightly lower than the values given by Eastman for arterial blood of babies delivered from unanesthetized mothers. When delivery was accomplished with forceps and the anesthesia more prolonged (average 15 minutes), the oxygen content of the arterial fetal blood was lower, having as an average 40 per cent saturation. The studies made during cesarean sections had to be classified into two groups. In ten of these cases oxygenation approximated the values found in other deliveries averaging 35 per cent saturation. In the others the oxygen content was very low, amounting to only one volume per cent in the lowest recorded. The average figure in this latter series of eight cases was approximately 8 per cent arterial blood oxygen saturation. The reason for this wide variation in oxygenation of the two groups of cesarean sections could not be determined. There was some correlation with the elapsed time from incision of the uterus and delivery of the baby. When delivery was promptly completed after opening the uterus, the oxygenation of the fetal arterial blood was low. When there was a delay of five or more minutes after incision of the uterus before the baby was delivered, the oxygenation was higher. It would not be unreasonable to assume that mechanical stimulation of the uterus during cyclopropane anesthesia may cause a reflex contraction of this muscle and interfere with oxygenation of the fetus. If delivery is delayed, the reflex stimulation may be lost and better oxygenation ensue. During studies on experimental animals, Barcroft found that the oxygen content of the umbilical vein varied with

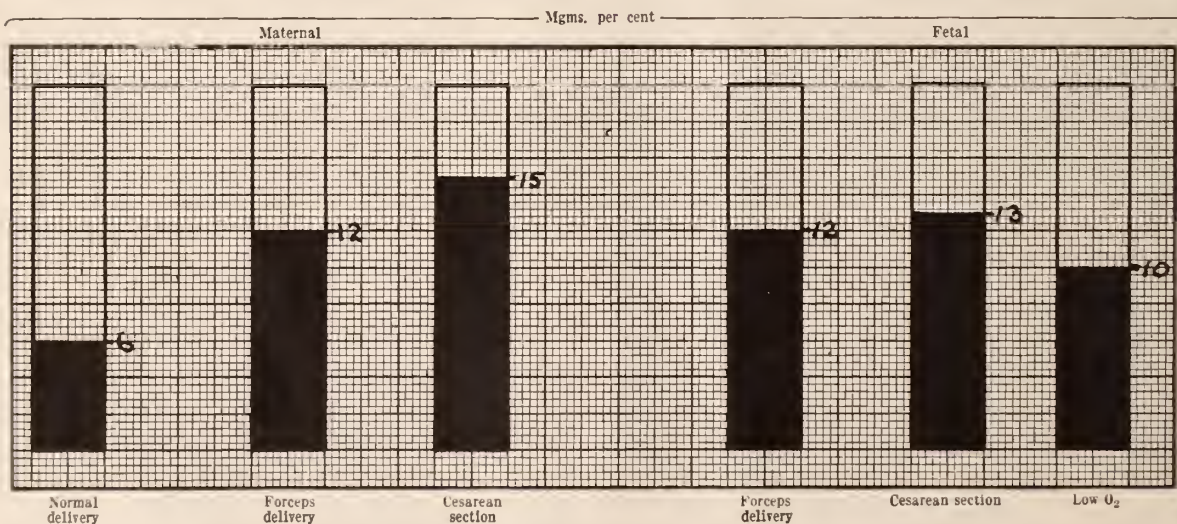


Fig. 6.—Blood concentration of cyclopropane.

the technique employed and the elapsed time in which the cesarean section was performed.

In these studies there was no correlation between the oxygen content of fetal arterial blood and the period of gestation. Whether or not the mothers were in labor at the time of operation seemingly had no influence upon fetal blood oxygenation. The average carbon dioxid content of arterial fetal blood of those cases with adequate oxygenation was 44 volumes per cent. In babies with low oxygen content the carbon dioxid was considerably higher, reaching values up to 60 and averaging 55 volumes per cent. The values found by Eastman in un-anesthetized babies were approximately 44 volumes per cent.¹

The cyclopropane content of the maternal blood varied with the duration of anesthesia. In normal deliveries the range was from 5 to 12 milligrams per 100 cubic centimeters of blood. When forceps were used and anesthesia prolonged, the arterial cyclopropane averaged approximately 14 milligrams per 100 cubic centimeters. This value was slightly higher in cesarean sections, averaging 15 milligrams per 100 cubic centimeters. The cyclopropane content of the fetal arterial blood varied, likewise, with the depth and duration of anesthesia. In normal deliveries the range was from 2 to 8 milligrams per 100 cubic centimeters, while in those done with forceps the average was approximately 12 milligrams per 100 cubic centimeters. The highest values for cyclopropane in fetal blood were in cesarean sections which averaged 13 milligrams per 100 cubic centimeters. The cyclopropane content of the arterial blood of the fetus was found to be considerably lower in babies with low oxygen saturation than in those that were oxygenated. It was interesting to find a high carbon dioxid content with a low oxygen and low cyclopropane content. It suggests an interference in the transfer of gases from the mother to the fetus. Asphyxia may alter placental permeability so that cyclopropane and oxygen are not so readily transported to the fetus, and similarly carbon dioxid is less easily transferred to the maternal circulation.

This study was undertaken primarily to learn the effects of cyclopropane anesthesia upon the saturation of fetal blood with oxygen and carbon dioxid. It was presumed that changes in the concentrations of blood gases would have an effect upon the initiation of respiratory efforts of the newborn. In this small group of cases no such correlation could be made.

In some cases with a very low oxygen saturation the initiation of respiration was prompt, while in others with similar oxygen content beginning respirations were delayed as much as eight to ten minutes. In normal deliveries the initiation of respiration was immediate in all six cases. In these the cyclopropane concentrations in the fetal blood were lower than in the other group.

One would hesitate to argue from these results that anoxemia at birth was unrelated to asphyxia neonatorum. The evidence already accumulated by Eastman,¹ Wilson,⁷ and others cannot be refuted. It would not be logical to conclude that cyclopropane in the fetal blood delays the initial respiratory effort. Babies with 15 milligrams of cyclopro-

pane per 100 cubic centimeters of blood breathed promptly. It can be stated, however, that this study adds to the accumulated indications that several factors influence the onset of respiration. It is almost certain that low oxygen saturation of fetal blood at birth is one of the more prominent of these factors, and it is not unlikely that high concentrations of cyclopropane in the blood may be another.

The data collected in this study are of little value in determining the effects of cyclopropane upon the fetus. The gas is promptly eliminated from the maternal blood and tissues, and it is not unreasonable to assume it is the same from fetal tissues, since elimination of inert gases follow physico-chemical principles. The effect of cyclopropane upon fetal nervous tissue and reflexes is still unknown. The effect of cyclopropane on the fetal respiratory mechanism and the mechanism which initiates respiration is certainly not known.

Any procedure or drug which interferes with placental circulation during or before birth should be used cautiously and judiciously. In all analyses completed there was a lowering of the oxygen content of the arterial blood of the fetus at the moment of birth during cyclopropane anesthesia. This does not contraindicate the use of the drug, but it would seem to suggest that when cyclopropane anesthesia is employed for obstetrical patients the degree of narcosis should be carefully adjusted. In this clinic such anesthesia is never deliberately carried beyond second plane third stage.

SUMMARY

The oxygen, carbon dioxid, and cyclopropane content of arterial and venous blood from the mother and infant has been determined during administration of cyclopropane anesthesia for delivery. Deliveries completed spontaneously, with forceps and by cesarean section, were included.

The maternal blood oxygen content was found to be increased, and the carbon dioxid content little altered with cyclopropane anesthesia. Cyclopropane was present in the fetal blood in concentrations approaching those of the mother. The fetal blood oxygen content at birth varied widely in the different cases studied. It was not found to be more than the oxygen content reported from studies of fetal blood completed without maternal anesthesia. The variations in oxygen content of fetal blood could not be correlated definitely with other factors involved in delivery. There was no direct correlation between the oxygen or cyclopropane saturation of fetal blood and the initiation of respiratory activity.

The data collected could not be interpreted in favor or against the use of cyclopropane for obstetric anesthesia. It did suggest that when it is used the degree of narcosis should not exceed the upper planes of the surgical stage.

477 First Avenue.

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AMPUTATION THROUGH THE LOWER THIRD OF THE FEMUR: A MODIFIED TECHNIQUE*

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PATIENTS upon whom it is necessary to perform amputations above the knee are often poor surgical risks. The vascular disease resulting in gangrene of the lower extremity, is only one part of a generalized process which may also have caused degenerative changes in the heart, brain, and kidneys. If diabetes is present, the susceptibility to infection is increased—a danger which, in any case, is great because of the bacteria in the lymphatic drainage of the necrotic area. In these patients, therefore, the plan of the operation and the manner in which it is performed, may determine whether the amputation is a life-saving or a life-taking measure.

SURGICAL PRINCIPLES

Certain surgical principles, which in the good-risk patient may be considered more lightly, must be strictly observed. The operation must provide for (1) the maintenance of maximum blood supply to all parts of the stump; (2) accurate hemostasis; (3) a minimum amount of devitalized tissue in the wound; (4) reduction to a minimum of the amount

of foreign material allowed to remain in the wound; (5) avoidance of muscle tissue; and (6) elimination of tension in the closure of all soft tissues.

Any present-day amputation can be but a modification of procedures that have previously been described, and any such modification has for its goal improved technique and end-results. I wish to present a procedure for amputation above the knee which, I believe, (1) simplifies the performance; (2) assures more strict observance of the surgical principles just listed; and (3) produces a most satisfactory stump.

AUTHOR'S MODIFICATION

The operation is performed with the patient in the prone position. By this means the important vascular structures of the posterior thigh are brought into easy surgical accessibility. Sandbags are placed under the upper part of the thigh to elevate the knee three or four inches from the table. The lower one-half of the thigh and the upper one-third of the leg are surgically prepared, and the lower part of the leg and foot are wrapped in sterile dressings to avoid contamination of the wound when the knee is flexed. The entire area is then brought through the opening of a laparotomy sheet so that free motion of the knee is permitted throughout the operation.

With the knee flexed at a right angle, an incision which extends to the deep fascia is made around the leg at a level corresponding to the lower end of the tibial tubercle. The ligamentum patella is incised transversely. The joint capsule is incised on each side of the patella to a level above the upper margin of the patella into the suprapatellar bursa, and the anterior superficial structures are separated from the capsule of the knee joint. The tendon of the biceps femoris is detached from the head of the fibula, by a crosswise incision close to the bone. The tendinous attachments of the semitendinosus, semimembranosus gracilis, and sartorius muscles are detached from the medial tuberosity of the tibia. The knee is extended and the popliteal space is opened in the line of incision. The popliteal space is exposed by retraction en masse of

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From the Rees-Stealy Clinic.



Fig. 1



Fig. 2

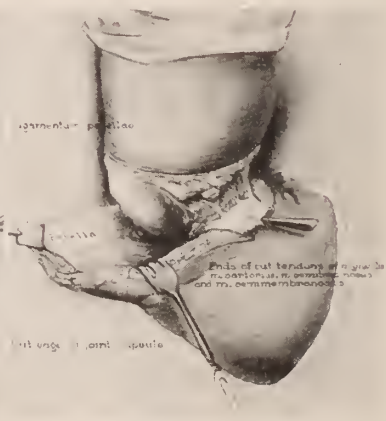


Fig. 3

Fig. 1—(a) Patient in prone position with sandbags under thigh. (b) Circular incision to the deep fascia at level of lower border of tibial tubercle. Patellar ligament detached. Incision of joint capsule over suprapatellar bursa.

Fig. 2.—Lateral view. Detachment of biceps tendon from head of fibula.

Fig. 3.—Medial view. Detachment of semitendinosus, semimembranosus, gracilis, and sartorius muscles from head of tibia.

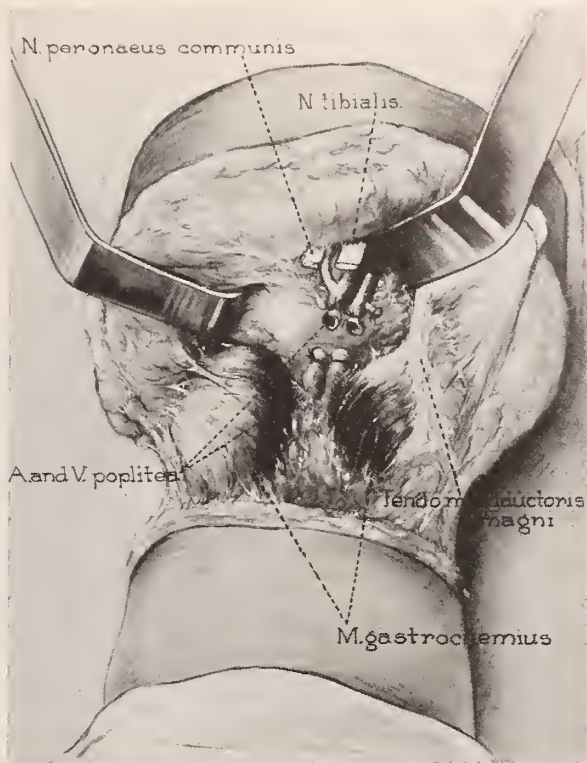


Fig. 4.—Popliteal space has been opened by incision of popliteal fascia, nerves have been divided, popliteal artery and vein have been divided and ligated.

the posterior structures which have been sectioned. The tibial and common peroneal nerves are located and sectioned as high as possible, and the popliteal artery and vein, or veins, are located and ligated separately, or together, and sectioned. The remaining fat of the popliteal space is cleared from the bone and patent arteries which form the anastomosis around the knee are ligated. The adductor longus tendon and the adductor fascia are detached from the tubercle, and the site for the section of the bone above the origin of the posterior crural muscles is selected. All soft tissues are retracted, the bone is sectioned, and the anterior margin of the bone is beveled. The patella is then removed from the capsule.

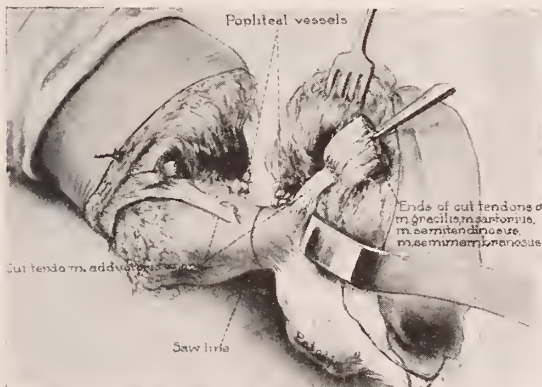


Fig. 5

Fig. 5.—Medial view. Detachment of adductor longus. Site of section of bone above the origin of the crural muscles and below the origin of the quadriceps tendon.

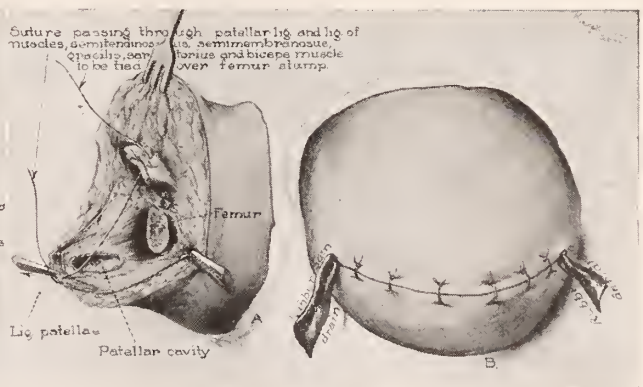


Fig. 6

Fig. 6.—(a) Patella has been removed. Single silk suture through all of the tendons except the adductor longus, ready to draw tendons over the end of the bone. Retraction of the posterior muscles covers the bone with the quadriceps tendon, and displaces the line of closure posterior to the femur. (b) Closure of stump. Drains optional.



Fig. 7.—End result. (a) Stump with quadriceps tendon contracted. (b) Stump with flexor tendons contracted. Voluntary movement of soft tissues over bone.

In closing, a single silk suture is passed through the tendon of each detached muscle, except the adductor longus, and tied over the end of the femur. The skin and superficial fat are closed transversely with loosely tied sutures, and a small drain, which is allowed to remain in place for twenty-four to forty-eight hours, is placed in each angle of the wound.

COMMENT

There are six outstanding advantages to the procedure which I have described:

1. The approach from the posterior aspect of the thigh permits full vision and easy surgical accessibility to the important structures throughout the operation, since the main and collateral blood vessels and the nerves at this level lie posterior to the femur. The tendon of the quadriceps femoris,

with its ligamentous expansion, is essentially the only important structure, from a surgical point of view, on the anterior aspect of the thigh. By this approach it is possible to secure accurate hemostasis of individual vessels with small ligatures, and to avoid mass ligations.

2. The circular incision assures a maximum blood supply to the superficial structures of the stump. The fact that flaps are not fashioned, obviates the necessity for lateral and medial longitudinal incision. Dissection within the remaining soft tissue is avoided, and retraction of these structures en masse, after sectioning, further assures uninterrupted blood supply.

3. The use of a single silk suture to draw the tendons of the detached muscles together over the bone results in an obliteration of dead space. As soon as the effects of the anesthesia have passed, muscular contraction retracts and stabilizes these structures snugly over the end of the bone. The use of only one suture also reduces the amount of foreign material left in the wound.

5. The avoidance of muscle tissue. This has been especially reemphasized recently by Callander, who has convincingly demonstrated a reduction in postoperative infection and mortality by minimizing trauma to muscle.

6. The end-result is an amputation stump in which the end of the bone is covered not only by skin and subcutaneous fat, but by tendons and deep fascia as well. The anatomical pattern of the remaining thigh is retained, and all soft structures to the end of the stump are movable by voluntary muscular action.

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DISSECTING ANEURYSM*

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ALTHOUGH less than four hundred case reports have been published, dissecting aneurysm is not very rare. Like coronary thrombosis a few years ago, it is now only beginning to be recognized clinically; but the antemortem diagnosis will undoubtedly become common with better understanding of the morbid anatomy and physiology of the condition and the corresponding clinical phenomena.

PATHOLOGY

Dissecting aneurysm is a separation of the coats of an artery by escaped blood. Of the reported cases all but a few were in the aorta, with or without extension to its branches. Three were in the pulmonary artery,¹⁰ and others have been mentioned in cerebral or other smaller arteries. The blood may come exclusively from vasa vasorum;¹¹ usually the intima is broken secondarily, if not initially. The cleavage plane is in the outer part of the media. If the adventitia is also quickly penetrated at a near-by point, the episode is spoken of simply as "*rupture of the aorta*": but more or less dissection is the rule in *spontaneous rupture*—not,

however, in traumatic rupture. Most dissecting aneurysms soon rupture externally—into the pericardium (more than 50 per cent), left pleural cavity, mediastinum, retroperitoneal tissue, or elsewhere. "Spontaneous" rupture of the undiseased aorta has often been mentioned, with the suggestion that it occurs at "points of lowered resistance," *e. g.*, at the site of a congenital stenosis or at the insertion of the atrophied ductus arteriosus. Two or three centimeters above the aortic valve is the common location. But in the absence of severe trauma, which is rarely alone responsible, it is probable that serial sections would show antecedent disease in most or all cases.

Syphilis is not the cause, and its sclerosing effect on the media may even prevent dissection—witness the patient of Weiss,¹² in whom dissection bordered but failed to invade a syphilitic area. Possibly other infections or obscure atheromatous lesions are at times responsible. But undoubtedly the usual cause is Erdheim's² *medionecrosis aortae idiopathica cystica*. These cysts, possibly of toxic or infectious origin, often multiple, of various sizes but often invisible to the naked eye, are filled with collagenous or necrotic material, and in their formation involve the destruction of medial tissue. They are found at times in the absence of dissecting aneurysm.⁹ The tears of the intima which they cause are occasionally multiple,⁸ and often appear as slits at a right angle to the direction of blood flow, *i. e.*, favorable to dissection. The aneurysm usually does not embrace the entire circumference of the aorta.

Dissection may progress gradually or intermittently, at times with arrest, thrombosis, organization, and repair; or it may rush through the entire course of the aorta and into one or more large branches. Branches may be choked, or small ones torn off in the process. External ballooning may compress neighboring structures, a remarkable example being that of George II of England, whose dissecting aneurysm compressed the pulmonary artery with resultant rupture of the right ventricle—the catastrophe while straining at stool.⁶ And the separated inner coats bulge into the lumen of the vessel and may more or less completely block it, reducing circulation below and raising pressure above. Occasionally this diversion of pressure forces the aneurysmal blood back into normal channels by rerupture into the lower aorta or into one or more of its branches. A few have survived after such an escape-valve effect, the new channel in time becoming endothelialized and carrying part or most of the stream.

DIAGNOSIS

The clinical picture of dissecting aneurysm, with its pain, anxiety, collapse and generally shock-like appearance, has been so commonly confused with that of coronary thrombosis that, in the following description, comparative remarks on the latter condition are included parenthetically. Most of the patients with dissecting aneurysm are middle-aged men, but many are under thirty-five. (Coronary: rare under thirty-five.) Three or four per cent of the reported cases were in advanced pregnancy.^{3,4}

* Read before the Section on General Medicine of the California Medical Association at the sixty-ninth annual session, Coronado, May 6-9, 1940.

(Coronary: no such pregnancy incidence.) Hyperpiesis is common. (Coronary: a smaller proportion with hyperpiesis.) Symptoms may begin when the patient is at rest or, more commonly, during exertion, which, however, may not be great. In seven reported cases the onset was associated with defecation, a pregnant woman was seized with pain while stooping, one patient when boarding a bus, another when tolling a bell,¹⁰ Middleton's⁹ patient while removing an overcoat, one of Davy and Gates¹¹ while stretching the arms backward, one of mine while reaching high up to insert an electric bulb, and another (patient of Dr. K. O. Haldeman) while leaning forward over a table—all suggesting contortion of the thorax as a precipitating factor. (Coronary: onset usually independent of any special exertion.) Early faintness or syncope is common, possibly reflex from the aortic depressor nerve originating at the base of the aorta; and with this may be nausea and vomiting. (Coronary: weakness, slowly developing, is common, but not initial syncope or vomiting.)

The pain may be little, discontinuous, or even absent, but is usually terrific; it may begin mildly and go on with cruel crescendo, but often strikes with explosive violence. Patients may cry out or writhe in agony. They use strong adjectives to indicate the intensity of the pain, but are often at a loss for similes to depict its quality. It may be stabbing, tearing, bursting, etc. Throbbing of the pain in synchrony with the heart beat was admitted by two recent patients. This is easy to understand when successive pulse waves are splitting the media bit by bit, or stretching the newly formed aneurysmal wall; and it may prove to be characteristic. Nitrites may or may not alleviate temporarily. A free interval of hours, days, or longer, often precedes the final rupture. (Coronary: pain may be absent, usually severe with crescendo, often with compression quality, and often preceded by effort-induced angina; attitude usually immobile—patient may sit up or pace the floor, but does not writhe. Pain usually not relieved by nitrites.) The pain commonly begins under the xyphoid and spreads up along the sternum and to the interscapular region; and, with advancing dissection, it is likely to spread down through the abdomen and lower back, perhaps to the legs. As a rule it does not enter an arm unless by cutting down the blood supply. But there are great variations. Radiated pain may open the scene, as in one man who went from his business desk to his exodontist when seized with pain in both lower bicusps. The dentist promptly sent him to my office in the same building, and by that time the pain was spreading throughout the chest, back, and abdomen. Necropsy the same day showed a tear in the ascending aorta with dissection all the way down and into both iliacs; rupture into the pericardium. (Coronary: pain occasionally epigastric, usually substernal, usually radiating to left arm or both arms, neck, jaw, or interscapular region; may spread, as from lower sternum upward, but not progressively downward as in extensive dissection.)

Depending on the location and degree of bulging into the lumen of the aorta, on involvement of its

branches, and on compression of surrounding structures by external expansion or hemorrhage, a great variety of phenomena are displayed. Blood pressure may be low, but is often high and may rise in one or both arms while it falls in the legs. (Coronary: usually a reduced, but well-distributed blood pressure.) Bizarre systolic murmurs or thrills may appear along the course of the aorta or its branches; and about one patient in five suddenly develops signs of aortic valve incompetence from distortion of the cusp anchorages. With slow oozing there may be a pericardial or pleural friction sound, and later signs of fluid—more often in the left pleural cavity, and sometimes serous in character. (Coronary: transitory pericardial friction common, but not fluid accumulation unless with congestive failure.) There may be increase in aortic dullness and tenderness in the suprasternal notch or along the abdominal aorta. And to the many proximal and remote effects of neighborhood pressure characteristic of other aneurysms is here added a great array of possible disturbances from widespread and sudden choking of nutrient arteries to brain, cord, extremities, and viscera. Among those mentioned are: reduction or absence of femoral pulses, inequality or asynchrony of carotid or arm pulses, partial or complete paralysis of one side of the body or of one or more extremities, paresthesias, loss of sphincter control, tympanites, and hemoglobinuria. The neurologic changes may be inconstant.

The x-ray may furnish important evidence, such as a denser shadow inside the enlarged aortic silhouette, an arcuate protrusion with or without pulsation, dissection enlargement of branches, displacement of trachea or esophagus, or indication of escaped blood in a pleural cavity or elsewhere.¹⁸ The usually unmodified electrocardiogram serves to exclude coronary obstruction; but it is possible for dissection at the root of the aorta to close a coronary ostium, and fluid in the pericardium may cause deceptive electrocardiograms. As in coronary occlusion, the acute attack may be followed by fever, leukocytosis, and accelerated sedimentation rate.

PROGNOSIS

About 90 per cent die from rupture in the first few hours or days, and the few survivors are likely to be cardiac cripples because of diminished caliber of the aorta, aortic valve incompetence, arteriovenous communication, or other defect. Osler⁷ describes a man who lived comfortably for over thirty years with a double-tube aorta, resulting from dissection and rerupture.

TREATMENT

Liberal use of opiates is in order for pain and restlessness; and blood pressure should be kept constantly as low as possible and tolerable. Erythrol tetranitrate 0.015, if tolerated by the stomach, is desirable for its sustained effect—about four or five hours. Copious venesection seems logical to reduce pressure and blood viscosity and to promote coagulation.

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SOME ASPECTS OF NUTRITION IN SURGICAL PATIENTS

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PART II*

WOUND HEALING

IN a study of wound healing which Smelo⁹ made in my department in 1935, he concluded that "factors other than the local dressing appear to play the dominant rôle in determining the rate of wound healing." Anderson,¹⁰ continuing these studies, stated that "the healing of granulating wounds under normal conditions, as determined by precise volume measurement, occurs according to a regular geometric curve which may be expressed in function of area and time by the mathematic equation presented by Carrel¹¹ and DuNouy¹² for the normal cicatrization of clean surface wounds."

That disruption is still encountered in wounds free from infection in which hemostasis was excellent, in which trauma to tissues and tension were minimal, and unusual strain obviated, strongly supports the concept that other factors of a general character play an important part in the failure of certain wounds to heal. That purely local factors may intensify the factors of a biologic character will not be doubted by anyone who has carried on investigations in this field.

We have shown that dogs which have been made hypoproteinemic by prolonged feeding of a low protein diet and plasmaphereses have a marked delay in fibroblastic proliferation, and thus wound healing is retarded. The hypoproteinemia in our animals was but one manifestation of the protein

starvation of the dogs. Although at first we were inclined to attribute the delay in fibroblastic proliferation to the presence of edema, we are now convinced that the mechanism is associated with a profound disturbance in protein metabolism, the hypoproteinemia being only an easily measurable indicator of the extent to which so-called labile stores of protein have already suffered.

It is well known that cellular repair and regeneration require protein, for in the absence of an adequate amount of certain essential amino-acids growth cannot take place. Admont Clark¹⁴ has shown that on a diet high in protein there was no quiescent period in the repair of wounds, and Harvey and Howes¹⁵ have reported that such a diet causes accelerated fibroblastic proliferation. Without adequate building stones, repair cannot take place.

A protein deficiency is, of course, not the only mechanism resulting in wound disruption. Sokolov¹⁶ and Lanman and Ingalls¹⁷ have shown that a vitamin C deficiency is also an important biological factor in this complication. These two nutritional disturbances are frequently found in patients who come for operations for gastric ulcer and cancer, duodenal ulcer, and biliary tract disease. That plasma may be used to replenish depleted protein stores was indicated in the experiments in which we gave large amounts of plasma, as much as 2,400 cubic centimeters, during a two-week period to hypoproteinemic dogs that had been on a low protein diet for some days. The amount of plasma which we administered intravenously was more than six times the calculated plasma volume of the animal, but the plasma protein concentration never exceeded the original normal level for the dog. With the restoration of a normal serum protein concentration and very likely a more nearly normal store of tissue protein, the wounds promptly healed. Addis and his associates⁴ and Holman, Mahoney, and Whipple¹⁸ have found that plasma protein can be utilized to replenish the depleted stores of tissue protein, and it is this purpose, we believe, that the excess protein fulfilled.

When all the local factors favoring wound disruption are controlled, there will remain wounds whose failure to heal must be due to more widely acting causes such as hypoproteinemia and a reduction in the labile protein stores, and deficiencies in important accessory foodstuffs.

DIET AND SUSCEPTIBILITY OF THE LIVER TO INJURY

Data which Goldschmidt, Vars and I¹⁸ have collected during the last few years strengthen the impression that the susceptibility of certain tissues to injury by a variety of chemical agents may be influenced by the composition of the organ at the time of injury. We have paid particular attention to this relationship in a single organ—the liver, but the data we have simultaneously collected indicate that the relationship may have a much wider application. That a diet high in carbohydrate is protective, and that a diet high in fat induces maximal susceptibility of the hepatic cells, when the liver is exposed to chloroform, has been re-

* Part I appeared in the July issue on page 10.

peatedly confirmed since first it was reported by Opie and Alford¹⁹ in 1914.

It is generally agreed that fasting markedly intensifies the susceptibility of the hepatic cells to injury by chloroform.

In the experiments I shall review, the diets have been adequate and feeding prolonged; the hepatic glycogen and lipid concentrations have been determined analytically on control animals (rats) before, and on the experimental animals after, anesthesia with chloroform.

Prolonged dietary régimes with chemical analyses of the resultant composition of the liver have yielded information which, when correlated with the histological evidence, reveals the influence of each of the foodstuffs in modifying the degree of hepatic injury produced by uniform periods of chloroform anesthesia. The evidence we have collected has led us to certain deductions concerning the mechanism by which a high carbohydrate, fat, or protein dietary conditions the susceptibility of the liver to injury by chloroform.

Whatever may be the fundamental reasons for the toxic action of chloroform upon the hepatic cells, our data point strongly to the fact that both the incidence and degree of injury increases in the concentration of lipid in the liver.

No evidence has been obtained by us that the level of the glycogen *per se* in the liver, at the time of anesthesia, influences the toxic action of chloroform. Although I have searched for it, I have found no completely satisfactory theory to explain the protection conferred upon the liver by a high carbohydrate diet. That a diet rich in carbohydrate protects the liver, I do not doubt.

It seems to us that the explanation of the protective action of a high carbohydrate diet lies in some concomitant effects produced when large amounts of glycogen are laid down in the liver. Rosenfeld²⁰ found that, under many conditions in the body, the depletion of hepatic glycogen is followed by an increase in fat in that organ, and vice versa. While the Rosenfeld hypothesis holds true under many conditions, we have by diet, in both the experimental animal and man, shown that there may co-exist in the liver a high concentration of glycogen and a high concentration of lipid. A great many data which we now have in both the experimental animal and man show that the reciprocal relationship of Rosenfeld is not an invariable rule.

We have shown that the susceptibility of the liver to injury by chloroform is progressively enhanced by the presence of increasing concentrations of lipid. In view of this it would seem plausible to conclude, since glycogen as such is ineffective even at low levels of hepatic lipid, that the protective action of a high carbohydrate diet is due chiefly to its effect in reducing the stores of hepatic lipid. In order to do this the carbohydrate must be given in adequate amounts and for a sufficiently long period. This explanation satisfactorily accounts for our failure to obtain protection from injury by chloroform when glucose was administered during the period of anesthesia. The addition of an adequate amount of protein (17 per cent or more) to the dietary provided livers which, even

in the presence of a low concentration of glycogen and a high concentration of lipid, were protected to a degree against the toxic action of chloroform.

Any comparisons of the relative protection offered by a carbohydrate and a high protein diet are futile unless the lipid contents of the livers are known. The value of the foodstuffs to the liver in protecting it against chloroform resolves itself into the positive action of dietary protein, the indirect action of carbohydrate, and the increased susceptibility due to hepatic lipid.

In view of the high degree of protection which a high protein dietary confers upon the liver, it should be pointed out that a carbohydrate diet may also be of value under conditions in which it can act as a sparer of the protein stores of important viscera.

While carbohydrate exerts only an indirect action in decreasing the damaging effects of chloroform upon the hepatic cells, the protection afforded by a high protein diet appears to be more direct and related to some intrinsic value of the protein itself. In this respect the finding that a previous high protein diet protects the liver against necrosis by chloroform at a high level of hepatic fatty acids assumes an added significance.

The mechanism by which the protein of the diet aids the liver in resisting the necrotic action of chloroform, with our present information, can only be a subject of conjecture.

The question of protein storage in the body, on a high protein diet, becomes of particular importance in relation to the protection conferred by such a diet, especially if we assume that it is due to protein *per se*. It is of interest that investigators in the field of protein storage have invariably directed their efforts to the liver as the major storehouse for protein.

There is some basis for believing that a high protein diet previous to liver injury by chloroform may make available stores of protein within the body. This protein, stored or elaborated into hepatic or other body tissue, may serve to protect the cells or to replenish a structure which is being or has been attacked. The available stores of protein may prevent or ameliorate the destructive action of the chloroform or the damage which occurs may be rapidly repaired so that it does not proceed to necrosis. Our data show that the main result of a high, as compared with a low protein diet is to decrease the incidence of hepatic necrosis. It is, of course, possible that the processes of damage and repair may conceivably be proceeding at the same time.

From these data and others soon to be published, we have concluded that a liver high in fat and low in protein is maximally susceptible, while a liver low in fat and high in protein is maximally protected against the effects of fat-soluble hepatotoxic agents.

The problem of liver injury following anesthesia has concerned the surgeon chiefly in biliary tract disease. In order to condition minimal injury, it is important that the lipid deposits of the liver be decreased as much as possible prior to operation. Johnson, Vars, Zintel, and I²¹ have studied the

effectiveness of various diets in decreasing the hepatic lipid in the presence of common duct obstruction in the dog. The data may be summarized by stating that a high carbohydrate-high protein diet is twice as effective in this respect as is a high carbohydrate diet alone, given in the same number of calories per kilogram of body weight per day. In conditioning the liver to minimal injury, or in providing for repair subsequent to injury, it is necessary that a diet of suitable composition be administered and that the total caloric intake be adequate for the energy requirements of the individual and for providing for the replenishment of the depleted storehouses of body foodstuffs.

Best, Channon, and their coworkers²² have reported, and we have confirmed their findings, that a high protein diet is conducive to a lesser deposition of hepatic lipid. The level of hepatic lipid and glycogen are from our data markedly affected by the amount of protein in the diet.

The hypotheses which assume that glycogen *per se* is effective in protecting the liver against the action of chloroform receive no support from our data. It protects if, during its deposition in the liver, the concentration of liver lipid is reduced, and probably is, as the result of an adequate store of glycogen, it spares the hepatic stores of protein.

Studies we are now making in man confirm the data we have obtained from the rat and dog, that a high carbohydrate-high protein dietary is the most efficient in conditioning a liver with adequate glycogen, low lipid and high protein concentrations. It is, we believe, the type of diet which will result in minimal injury and provide for rapid repair of existing injury when the liver is exposed to a variety of hepatotoxic agents.

We believe that if food can be taken by mouth this is the best method of obtaining the desired objective. If the patient will not eat the necessary amount, or if it is desirable that food not be placed in the stomach, the orojejunal method which Stengel and I²³ have described provides an efficient means of introducing sufficient calories of suitable composition. Where it is desired rapidly to replenish depleted stores of protein in the plasma or tissues, we believe that the intravenous injection of plasma is at present the most effective means of obtaining this. The intravenous injection of plasma is not attended by the postinjection reactions that so frequently follow the use of serum. We have administered intravenously amino-acid mixtures, made from the hydrolysis of casein and soy bean, reinforced with tryptophan, cystein and methionin; and while we have kept the dog and man in positive nitrogen balance there has been no evidence that the total plasma or liver protein, or the protein concentration of the plasma was replenished following a period of protein depletion.

A better understanding of these and many other problems of nutrition, which are constantly present in surgical patients, will lead to a further reduction in the morbidity and mortality of anesthesia and operation in a wide variety of conditions.

The nutritional state of the individual has been considered to bear some relationship to general resistance. I hope that I have shown you that the

part which it plays is much more important than is generally supposed. Such serious complications as failure of a gastro-enteric stoma to empty, wound disruption, or serious hepatic necrosis, can in large part be prevented by restoring the storehouses of protein prior to operation and maintaining them after operation.

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HISTORY OF THE ANESTHETIC DEPARTMENT AT LANE STANFORD UNIVERSITY HOSPITAL IN SAN FRANCISCO*

By ADENA C. DUTTON, M.D.
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LANE HOSPITAL was built in 1893 by Dr. Levi Cooper Lane on land donated by Captain James M. McDonald. The Hospital was under the supervision of a committee from the faculty of Cooper Medical College until 1912. At this time formal transfer was made to Leland Stanford, Jr., University, and the entire faculty was retained as a part of the new hospital staff. All activities of the Hospital were under the control of the Clinical Committee from the Medical Department of the University.

BEGINNING OF THE DEPARTMENT ON ANESTHESIA

Dr. Henry Gibbons, then dean of the Cooper Medical School, had asked Dr. Caroline B. Palmer, a graduate of the class of 1906, to take charge of

* Chairman's address before the Section on Anesthesiology of the California Medical Association at the sixty-ninth annual session, Coronado, May 6-9, 1940.

the administration of anesthetics. This step was made in 1909 toward the formation of a regular department in anesthesia because of Doctor Gibbons' concern over some fatalities which had occurred. Doctor Palmer acted in that capacity as head of the department for twenty-eight years, reaching her age for retirement in September, 1937.

Doctor Palmer's first interest in anesthesia began as a medical student at the San Francisco County Hospital, when she saw a patient die during induction. She felt that anything as important as anesthesia should have more serious attention than it was receiving in those days. Diligent study and close observation of anesthetics, given by Dr. Mary Botsford, qualified Doctor Palmer to administer many anesthetics during her internship at the Children's Hospital in San Francisco between 1906 and 1907.

After her appointment at Cooper, she visited all major medical centers where anesthetics were given. In this manner she became acquainted with the work of Dr. Isabella Herb in Chicago, of Dr. Gwathmey in New York, and of Dr. Richardson, the so-called Dean of Anesthesia, in Boston.

She also gained a thorough knowledge of all anesthetic agents by inspecting different manufacturing plants. At E. R. Squibb and Sons, in New York, she met Doctor Ferguson, who was in charge of their anesthetic department, and was given access to his personal library on anesthesia, then the largest in the United States.

Doctor Palmer took advantage of every opportunity available in this country to further her knowledge of the art of practicing anesthesiology as a medical specialty, and to qualify herself to train other doctors to become specialists in this field.

The proper psychic preparation of every patient was always stressed by Doctor Palmer. She believed and taught that the carefully regulated dosage of a hypodermic was a part of the anesthetic. Practically all patients received a hypodermic injection of morphin sulphate and atropin; but this did not include those under five and over seventy.

EXPERIENCES WITH VARIOUS ANESTHETICS

In the early days, heroin was used when the patient was said to be unable to tolerate morphin. Scopolamin, replacing atropin for a period of years beginning about 1924, was favored by some surgeons.

In June, 1929, a barbiturate was first introduced into the list of premedication agents; it was sodium amytal, used only intravenously. The clinical experiences at Stanford with it as an auxiliary anesthetic were published in the *American Journal of Surgery* in July, 1930. But its intravenous use was soon discontinued, because of the lengthened and complicated postoperative nursing care required. Later the oral administration of other sedatives gave more satisfactory results; these preparations were sodium amytal, luminal, allonal, nembutal, seconal, and barbital. For a period barbital was given alone or combined with sodium bromid. Sodium luminal, hypodermically, was used when ingestion of any drug was contraindicated.

In 1932, avertin, or tribromethanol, was employed to produce basal anesthesia in combination with local infiltration or with nitrous oxid-oxygen. In brain surgery ether vapor was used, and then this was replaced by local infiltration of novocain. Latterly, since its introduction, all major brain surgery is done under avertin combined with local novocain.

Paraldehyd given by rectum was used for a short period in gynecologic surgery, but was replaced by avertin or by scopolamin. Since 1936, paraldehyd has been used advantageously by several otolaryngologists for tonsilleotomies. Some evipal, intravenously and rectally, and pentothal sodium has been used since 1934. Morphin sulphate and scopolamin, in a single dose, is given one and one-half hours before operation, or, in divided doses, two and one-half and one and one-half hours before the use of the more potent cyclopropane anesthetic agent.

Dr. R. L. Rigdon began the use of spinal anesthesia in genito-urinary surgery at Stanford in 1919. Tropococain was the drug used. This was later replaced by neocain and by novocain and pantocain. Spinal anesthesia was only occasionally used before 1929; after which time its popularity increased. The reasons for this were the preliminary use of ephedrin and, later, the control of the level of anesthesia by raising or lowering the head of the operating table.

HOW RECORDS WERE KEPT

The first records of anesthetics administered were written in ordinary student notebooks. In December, 1917, the first book of printed reports in duplicate was used. This was at the suggestion of Dr. Emmet Rixford. The form was designed after a study of records in use in the larger hospitals in the country at that time. Through the years modifications were made according to the changes in methods of administration and in operative procedures. The one in current use has complete pre- and postoperative information on the reverse side, and is filed in special departmental files.

COSTS OF ANESTHETIC AGENTS

In the early days ether was commonly used because of the prohibitive cost to the patient of anesthetic gases. Chloroform was used only upon the insistence of the surgeon. Doctor Palmer, early in her career, believed that the addition of oxygen to ether was less irritating and better for the patient than ether dropped on a mask. The earliest method of administering ether vapor was by using a hand bulb to force air through a large Erlenmeyer flask of ether held on the anesthetist's lap. Later a foot bellows replaced the hand bulb, and the flask was set in a depression on top of a wooden stool. Realizing that a better arrangement could be made, Doctor Palmer designed a vapor machine in which oxygen, in a low pressure cylinder of 125 gallons, was used. There was an inlet for the use of compressed air when it was available. A Murphy drip bulb placed in the tubing leading to the patient prevented liquid ether from being given accidentally. One cylindrical bottle contained water in the event

that oxygen was to be given without ether. The other cylindrical bottle and flask, with a larger evaporating surface, contained ether, so that a stronger concentration could be produced without heating the ether. This measure was taken to prevent the formation of irritating aldehyds and ketones. For an improved vapor machine, Doctor Palmer later utilized the high-pressure controls on the Ohio monovalve machines. Four high-pressure cylinders, containing 130 gallons each, were used. Two of these contained 100 per cent oxygen and two contained a mixture of carbon dioxid and oxygen. The three glass containers and Murphy drip bulb were retained. Ether vapor was commonly introduced through a hook in the mouth or a nasal catheter, but by designing a special perforated mask Doctor Palmer made its use adaptable for major surgery. The administration of nitrous oxid, with adequate oxygen, to young children (the youngest two months old) has been safely conducted at Stanford for many years.

OTHER OBSERVATIONS

One of the early improvements in anesthetic procedures was attention to posture of the patient on the operating table. Positions which facilitated operating and protection against nerve injuries, or those unduly tiring to the patient, were developed and used by Doctor Palmer. Beginning supportive measures early, by maintaining body fluids and by preventing heat loss, operative shock was kept down to a minimum. Special protective care has always been taken in transferring patients to and from operating rooms.

The first administrations of nitrous oxid were with a White dental machine. Oxygen, when added, was given by means of a catheter in the nose or by a hook in the corner of the mouth. Cylinders were used which contained one hundred gallons and cost \$3 each.

A first model Teter machine was purchased which would enable oxygen to be given simultaneously with nitrous oxid. There was no mixing chamber—each gas being allowed to flow to the patient independently through a single tube and face inhaler.

There was always great objection to the cost of anesthetic gases. These were first obtainable on the Pacific Coast only in small cylinders. About this time Doctor Botsford went to Cleveland to attend the clinics of Doctor Crile, who was doing operations under gas and oxygen. While there she visited the Ohio Company and found that gas in large cylinders could be sent to San Francisco at half the cost per gallon of that in the small cylinders. So it was arranged that the gas should be shipped from Ohio, and the cylinders received were stored in the basement of the apartment building where Doctor Palmer resided. After two years a distributing office was opened in San Francisco. Eighty dollars for a cylinder containing 3,200 gallons was paid for those sent to California from Ohio.

In 1924, Dr. Donald Baxter began the manufacture of nitrous oxid in Glendale. Doctor Palmer visited his plant and was satisfied that the quality

was equal, if not superior, to that then in use. A price of \$54 a cylinder, plus the freight charge, was paid. After Doctor Baxter established the Certified Laboratories Products Company in San Francisco, the price was reduced to \$40 a cylinder on a contract with Stanford. As the cost of manufacture lessened, the price of nitrous oxid became lower, until it is now about \$23 a cylinder.

The original charge to the patient was \$10 an hour. The business manager of the Hospital complained to Doctor Somers, then the medical director, that \$200 had been spent on gas in the year 1911, but the monthly report showed that more than that amount had been received by the Hospital. By using the tailings for induction, a surplus developed so that one of the sources of income for the Hospital was from this charge. The cost to the patient was then reduced to \$6 an hour. After the introduction in 1935, and the increase in use of the absorption technique, a further saving was possible, allowing another reduction in charge for gas. A blanket charge of \$2.50 is now made for every anesthetic procedure exclusive of locals.

Many times patients whose physical condition required a less toxic agent could not receive it because of the prohibitive price. The blanket charge at present assures a satisfactory income to the Hospital to cover the cost of machines, equipment, and agents. Thus an enviable goal has been reached. Every patient can now receive the agent or agents best suitable to his physical condition and the operative procedure, without being hampered by the question of cost.

In conclusion, permit me to quote from Doctor Palmer's chairman's address in 1933 on "The Future of Anesthesiology as a Medical Specialty": "The members of the anesthetic department in the institution with which I have the honor to be connected have reason to feel fortunate in the attitude toward anesthesiology of the medical school authorities, surgeons, internists, and hospital executives."

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EARLY CARE OF SEVERE THERMAL INJURIES*

By H. McCORKLE, M. D.
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SEVERE thermal injuries are of rather frequent occurrence on large emergency hospital services, and they occur often enough in private and industrial practice to deserve the attention of surgeons everywhere. One may review the contributions made in the past few years by surgeons and physiologists and say, with confidence, that much has been done to improve both the local and the general aspects of the care of burned patients. To these contributors we must acknowledge a debt, and to them we look for further progress in the future.

* Read before the Section on Industrial Medicine and Surgery of the California Medical Association at the sixty-ninth annual session, Coronado, May 6-9, 1940.

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PAIN AND SHOCK

The immediate concern of the surgeon who must treat a severely burned patient is the control of pain and shock. The patient is not removed from his original emergency dressing until shock and pain have been alleviated. An effective dose of sedative (morphin for adults, codein for children) is given. The patient is put in a warm place and additional heat is applied as indicated. A transfusion of blood is arranged at once and, in cases where shock is not otherwise controlled, is given before local treatment is instituted. The general appearance of the patient, the blood-pressure readings, and pulse observations are the criteria for decision as to when local treatment may be started. Under no circumstances is the local treatment begun before the surgeon is certain that the primary shock has been overcome.

LOCAL TREATMENT

The basis of our present local treatment of second- and third-degree burns is the tannic acid method of Davidson, with the addition of silver nitrate as described by Bettman. Following a favorable response to shock therapy, the original dressing is gently removed from the patient. If the original dressing is one of the tannic-acid jelly preparations, or simply sterile dressings, or even a clean sheet, we are indeed grateful to the referring physician. If, however, the original dressing contains some sort of grease, it is necessary to remove it with ether. The patient is then placed in a tub of comfortably warm water, to which tannic acid powder (enough to make the water appear muddy) has been added. The skin is cleansed with sterile green soap and water. With scrubbed hands encased in sterile gloves, and with sterile instruments, the operator removes blisters and loose epithelium as the patient lies in the tub. The patient remains in the tub usually for about thirty minutes, during which time the fluid may be changed once or twice. He is then placed on a sterile sheet and dried with sterile towels. The partially tanned burned areas are then treated with 10 per cent silver nitrate solution, which is applied with gauze pledgets. This causes some temporary smarting. In a few minutes a coagulum is obtained that would require twelve to forty-eight hours with the tannic acid spray method. The unclothed patient is then placed in bed on a sterile sheet under a light cradle that is kept comfortably warm at about 85 to 88 degrees Fahrenheit. This also serves to dry the coagulum. At frequent intervals (about every two hours) the burned areas are sprayed or sponged with one per cent aqueous gentian violet solution. The application of gentian violet is continued for several days, as it seems to prevent or minimize the occurrence of bacterial infection in the fissures that form at the margins of the tan and in the flexion creases. If a burn completely surrounds an extremity, it is usually expedient to split the coagulum over its entire length. This prevents ischemia of the limb, which might result as the coagulum dries and contracts. It may be split readily with a sterile scalpel and the defect sprayed as described above with gentian violet solution. It

has been found in practice that the fingers, toes, face, ears, genitalia, and anal regions do not tan well. The coagulum splits and separates in these areas. For this reason, in severe burns which include these regions, the tan is not extended into these areas. Instead, they are treated entirely with gentian violet solution.

If the preliminary cleansing has been done carefully and with aseptic precautions, infection beneath the coagulum rarely occurs. However, when it does occur, the tan must be removed and the infection treated. We usually employ saline compresses (changed frequently) or warm saline soaks followed by the application of fine mesh antiseptic grease gauze dressing. In most instances, however, gross infection does not develop.

GENERAL CONDITION

As soon as the work of tanning has been accomplished and the patient is in his bed, his general condition again becomes the primary concern of the surgeon. This has to do chiefly with the prevention and treatment of the so-called "burn shock" or "toxemia." While it is of real clinical value, as well as of scientific interest, to have laboratory determinations of blood and urine chlorids, blood proteins, carbon-dioxid combining power, hematocrit, nonprotein nitrogen, and so forth, carried out, it is not always practicable or possible. Much valuable information can be obtained, however, in every case by the simple daily determination of the hemoglobin, complete blood count, and urinalysis, including specific gravity readings of urine. It is also desirable to have a complete chart of the fluid intake and output, including an estimation of the amounts of emesis, perspiration, involuntary stools, and so forth. For this purpose special nursing is essential.

During the hours following a severe burn there is an extravasation of blood plasma into and about the burned area, and probably also into the tissues of other parts of the body. Apparently this is caused by increased capillary permeability, and results in loss of fluid, electrolytic substances, and protein from the blood stream. This, in turn, causes diminished blood volume, decreased cardiac output, vasoconstriction, circulatory stagnation, tissue anoxia and, in severe and untreated cases, circulatory failure and collapse. Clinically, this state is manifested by an elevated hemoglobin and erythrocyte determination, edema and vesicle formation at the burned area, alterations in the blood chlorid and protein values, and occasionally oliguria. There may also be lethargy on the part of the patient, and evidence of impending circulatory collapse, as measured by blood-pressure determinations and the quality and rate of the pulse, and a blotchy livid cyanosis of the skin.

Recent work (Trusler et al.) indicates that an excessive intake of water aggravates the above described condition of burn shock. Treatment of this phase, therefore, is directed toward the provision of a correct fluid balance with the addition of required salts and protein substances. The hemoglobin, erythrocytes, and urine are studied daily, together with the charted fluid intake and output.

For the first day a fluid intake of not more than 2000 to 2500 cubic centimeters for children, and not more than 3000 to 3500 cubic centimeters for adults, has been found adequate. Usually, similar daily amounts will be satisfactory for the ensuing two or three days; but they may be adjusted according to the needs of the patient as determined by the above-described studies. Often these amounts of fluid are taken easily by mouth. If only small amounts are vomited occasionally, additional fluids may be given as necessary. Where vomiting is continued or excessive, the fluids must be given parenterally, as glucose and saline solution. The amount of urinary output (500 cubic centimeters and preferably more, daily), the specific gravity of the urine, the moisture of the tongue, and the texture of the skin are practical means of estimating adequate hydration. Excessive amounts of fluid produce edema and may go on to cause a state of "water intoxication" with weakness, edema, muscular twitchings, and even coma and death. The amount of fluid, therefore, is carefully regulated, and the patient is neither given too much parenterally nor allowed to drink to excess.

As previously mentioned, a transfusion may be given to the patient soon after admission, to combat shock. When this is not done at entry, it is always done within a few hours after the tanning has been completed. When the loss of plasma has been great, as evidenced by high hemoglobin readings, the blood is administered preferably as a plasma or serum transfusion. Subsequent transfusions of blood plasma are given at least every twenty-four hours until the hemoglobin and erythrocyte readings approach normal. This ordinarily begins to take place after about seventy-two hours with the patient under treatment.

Usually the patient is able to take fluid nourishment in the first twenty-four to seventy-two hours, and may even eat a soft or regular diet. If not, parenteral administration of glucose is used to supplement the fluids, chlorids, and transfusions until eating becomes possible.

Sedation is necessary to control the initial pain in severely burned patients. After the tanning has been completed and the patient placed in bed, sedatives should be given only when necessary. Heavy sedation is always contraindicated in the very young and in the aged, and should be limited in all severely burned persons, because it may contribute to circulatory stagnation and tissue anoxia. This is especially true during the first seventy-two hours, when danger from the so-called "toxemia" or "burn shock" is maximum.

When the most dangerous period of the first few days has passed, the vigilance of the surgeon should not be suspended. It is important that the nutrition of the patient be maintained by adequate dietary measures, and that the red blood cell count and hemoglobin be kept at a high level by administration of iron and by transfusions of whole blood if necessary.

In areas of second-degree burns, the epithelium is restored rapidly and the coagulum begins to separate on about the seventh to the tenth day, and may be completely cast off by the fourteenth to

the twenty-first day. Areas of tan covering, third-degree burns may not separate, and if they adhere beyond the third week following the burn, they are removed surgically under light general anesthesia. The resultant granulating areas are then prepared for skin grafting with saline compresses or baths, or by the use of daily compresses of one of the chlorin antiseptics, preferably azochloramid. It is desirable to have the grafting of the skin done at the earliest opportunity.

University of California Hospital.

OBSTETRICAL COMPLICATIONS*

MAJOR COMPLICATIONS ENCOUNTERED IN 10,708
OBSTETRICAL CASES IN THE UNIVERSITY
OF CALIFORNIA HOSPITAL

By PURVIS L. MARTIN, M. D.
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THE treatment of obstetrical cases in the University of California Hospital, under the direction of Dr. Frank W. Lynch, has been essentially conservative in character. Methods of delivery naturally have been changed, from time to time, as a result of efficiency studies essential in a clinic designed primarily for teaching and research. The major change in treatment followed Dr. Alice Maxwell's¹ reviews of the contracted pelvis in this clinic prior to 1927, which showed too high a fetal and maternal mortality when labor pains were insufficient to completely dilate the cervix, yet exhaustion had occurred, indicating surgical intervention. Our four-year experience with the low cesarean operation by that time indicated that the procedure could be used after a certain amount of trial labor. We then did more cervical cesareans, and consequently fewer high forceps in such cases.

This present study, likewise, is intended chiefly as an efficiency study. It was planned primarily to review the cases delivered since Doctor Maxwell's study to determine to what extent our therapy had improved, and to evaluate various factors that had helped reduce our maternal and fetal mortality.

MATERIAL FOR THIS STUDY

The series comprises 5,780 cases treated between 1927 and 1937, inclusive. I had hoped to use, as a control series, the major complications occurring in the 4,928 cases delivered between 1916 and 1926, inclusive, but the "breakdown" of many of the groups of complications showed that there were often too few cases to permit direct contrast with mathematical accuracy. So, under most headings I have studied the complications in two series totaling 10,708 women delivered from seven months' pregnancy to term. All deaths occurring earlier in pregnancy, however, are included in the tabulations.

In order properly to describe our material to others, the rank and file may be said to be normal-appearing, white American women, among whom there are comparatively few who are yellow or

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colored or give evidence of chronic poverty. As a whole, the very major part of the material compares with obstetrical cases usually seen in general practice. However, a definite proportion of cases, both of the older and more recent series, have been desperately sick women who have been sent here by outside physicians because it is a University Hospital, for which reason it is ideal for teaching medical students.

CLASSIFICATION

I have reviewed the material under different headings, studying the various factors which frequently interfere with labor, and have considered the relative rôles of the pelvis, the presentation and position of the fetus, the character of the pains, the size of the fetus and the soft parts as etiologic factors for major operative interference. Pregnancy-complicating disease is also reviewed.

PRENATAL CARE

This study indicates that constant effort to persuade patients to report early in pregnancy for prenatal care is bearing fruit. In recent years a larger proportion has been reporting in the earlier months of pregnancy. In 1936, 38.7 per cent of cases received more than five months of prenatal care, as compared with 6.7 per cent receiving such care in 1925. In 1936 but 21.4 per cent received less than two months of prenatal care, as compared with 37.6 per cent in 1925; and yet the figures fall far short of the ideal standard that all patients should report before the end of the third month when pregnancy, in the face of contraindicating disease, could be terminated safely from below.

TABLE 1.—*Prenatal Care*

Per Cent of Cases Receiving Adequate Care		
Year	For More Than Five Months	For Less Than Two Months
1925	6.7%	37.6%
1936	38.7%	21.4%

CONTRACTED PELVES

Pelvic contraction, according to clinical methods of measurement and adhering strictly to classical definitions, was found in only 187 cases, or 1.75 per cent of the total series. In ninety-six of these, the pelvis was generally contracted with a diagonal

conjugate of 11.4 centimeters or less. In twenty-one cases the pelvis was funnel, with transverse outlet measurements of 7.9 centimeters or less. Thirty-six were simple flat pelvis, with a diagonal conjugate of 10.9 centimeters or less, along with normal width. Nineteen were typically rachitic, and in fifteen others the pelvis had been deformed or made markedly asymmetrical from causes other than rickets.

A large proportion of the records antedated the work of Caldwell and Moloy, and consequently the older classifications of pelvis were used in this study. As a rule, generally contracted pelvis correspond to the small gynecoid group, flat to the platypelloid group, and funnel to the android group of Caldwell and Moloy. Hayden,² who has recently reported from this clinic a series of five hundred consecutive primiparae studied by x-ray pelvimetry and classified according to the definitions of Caldwell and Moloy, finds approximately the same per cent of contracted pelvis in his group of cases.

Seventy-seven, or 41.2 per cent, of the 187 cases with contracted pelvis were delivered by cesarean section. Seventeen of this number were operated upon after some degree of test of labor, and sixty women were chosen for elective cesareans performed before the onset of labor. One woman died from sepsis following a seventeen-hour test of labor in the 1916-1926 series (maternal mortality 1.3 per cent). There were no fetal deaths in the cesarean group of contracted pelvis in either series.

This left 110 (58.8 per cent) to deliver from below. Ninety-seven, or 88 per cent, of these delivered either spontaneously, by low forceps, or by breech, with seven stillbirths (6.3 per cent), but without maternal deaths.

Thirteen women required either mid- or high forceps for delivery; there were two maternal and eight fetal deaths. One of these maternal deaths occurred in a nonregistered patient of the earlier series, who was admitted as an emergency case with an unengaged head and a completely dilated cervix. She had had several vaginal examinations, and attempt had been made to deliver on the outside. A resident failed to deliver with high forceps and again after he had performed a craniotomy. A staff member, also failing to deliver through natural passages, performed a modified Porro section, at which time a nonbleeding rent in the uterus was discovered. The woman died four days later from peritonitis. The other maternal death occurred in an undelivered patient from a ruptured uterus. She

TABLE 2.—*One Hundred Eighty-Seven Contracted Pelvis*

Type	Number Cases	Per Cent	Cesarean	Per Cent	High or Mid-Forceps	Per Cent
General contracted	96	51	26	27	11	11
Funnel	21	11	13	62	0	0
Flat	36	19	20	55	2	6
Rachitic	19	10	8	42	0	0
Deformed	15	9	10	66	0	0
Totals	187	100	77	41	13	7

RELATION FETAL POSITION AND PELVIS TO DIFFICULT LABOR

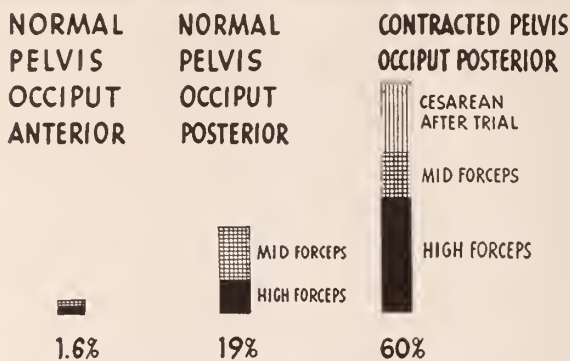


Chart 1

also was in the older series. Spontaneous uterine rupture had been diagnosed, and delivery by means of high forceps had been vainly attempted while preparations were being made for cesarean. Autopsy confirmed the spontaneous uterine rupture.

In each of the thirteen women requiring mid- or high forceps, either poor pains, posterior position, or a very large child was associated with the contracted pelvis in producing the indication for major operative intervention.

Study of these cases suggests that the majority of significantly contracted pelvises will allow of delivery from below, but the relative safety of such procedures depends upon the size and position of the child, the character of the labor and various other most important factors.

Fetal Position and Contracted Pelvises.—The relation of fetal position and pelvis to difficult labor can be readily seen in Chart 1.

Bell, in 1933,³ reported a 10 per cent incidence of occiput posteriors in a series of 7,600 cases in this clinic; but half rotated spontaneously to an anterior position. Our series closely parallels his, since we note persistent occiput posterior in 564, or 5.3 per cent, of 10,501 normal pelvises. In the 187 contracted pelvises, however, 25, or 13.3 per cent, persistent posterior positions were noted. In the group with normal pelvises and occiput posterior position, 113, or 19.1 per cent, required either a mid- or high forceps to effect delivery. But in the groups with posterior position and contracted pelvises, 60 per cent, or about three times as many, required either a mid- or high forceps, or a cesarean section after trial of labor; occiput posteriors which delivered spontaneously through contracted pelvises had either quite strong pains or small babies.

In other words, persistent occiput posterior position was more than twice as frequent in contracted as in normal pelvises, and the combination of posterior position and contracted pelvises resulted in a 60 per cent incidence of mid- or high forceps, or cesarean after trial of labor.

Poor Pains in Contracted Pelvises.—Poor pains were observed throughout labor in 22 of the 187 cases of contracted pelvises. Eleven of the twenty-two were delivered by cesarean section after a trial

of labor, and seven others either by high or mid-forceps. Only four of the twenty-two women who had poor pains and occiput posterior positions in contracted pelvises were able to deliver spontaneously.

Size of the Child and Contracted Pelvises.—The size of the child is another important factor in women with contracted pelvises. When the pelvis was generally contracted, the babies were usually smaller than in those with flat pelvises. Very large babies were unusual. In the entire series of 187 contracted pelvises, only seven children weighed more than 4,000 grams. These seven cases, however, occasioned much difficulty. Delivery was finally effected with high forceps in four of the seven cases, with two maternal deaths and fetal deaths in the four, all in the 1916-1926 group of cases. Cesarean sections after trial of labor were performed in two other cases, and the only patient which delivered spontaneously had extremely strong pains.

To summarize the problem of difficult labor: the choice of a method of delivery for any given cases is never complete without considering each of the five factors—pelvis, position, size of baby, character of pains, and condition of soft parts. The risk to mother and child is significantly increased when one factor is unfavorable, but is very greatly increased when two or more factors are unfavorable.

CESAREAN SECTION

Cesarean section in this clinic is performed only for precise indications. During the past thirteen years, however, the surgical mortality rate from the low cesarean sections has been so very slight (here in this clinic) that the indications for delivery by this means have been much extended. The incidence of cesarean operations in the last series of cases has doubled, yet there has been but one death in 278 cases, or .36 per cent in the 1927-1937 series. Prior to 1925 the classical cesarean was almost routinely used, but since that time it has been abandoned. We now aim to deliver, by low cesarean, women upon whom we formerly used high forceps. And yet even with our more frequent use of cesarean section (4.8 per cent) for the 1927-1937 period, we do not find need for the operation as often as do many others—5.66 per cent of all births in San Francisco, and 5.47 per cent of all births in the cities of Oakland, Berkeley, and Alameda from 1932 to 1936 were by the cesarean operation.⁴ This is in spite of the fact that many outside physicians bring many problem cases to the Hospital for delivery.

The policy of "once a cesarean, always a cesarean" has been strictly followed, and appears justified by the observation of three uterine ruptures through previous cesarean scars. One of these ruptures occurred in a patient who had previously been delivered, through a low cervical cesarean operation, by a well-qualified obstetrician, and who had had a smooth postoperative convalescence. At secondary section performed during labor in this Hospital, the previous scar was seen to have separated, allowing membranes to bulge through. The

TABLE 3.—Three Hundred Eighty-Eight Cesarean Sections

	Num- ber	Incidence	Maternal Mor- tality	Fetal Mor- tality
1916-1926 4,928 cases	110	2.23%	7.3 %	4.5%
1927-1937 5,780 cases	278	4.81%	.36%	2.5%
Total	388	3.62%	2.3 %	3.1%
Repeat sections	110	1.03%	.9 %	1.8%

other two ruptures were observed under similar circumstances; each followed a previous classical type of section performed by a general surgeon.

FORCEPS

Low or perineal forceps have been applied in 8.7 per cent of the total material. No insignificant increase in morbidity, mortality, or fetal mortality has been associated with this procedure.

Mid-forceps, however, is considered a major obstetrical operation, and is limited to compelling indications, usually maternal.

High forceps performed in the first series were attended with a 7.4 per cent maternal and a 38 per cent fetal mortality. In recent years we attempt to avoid this type of delivery, preferring a cesarean operation performed early whenever it seems practicable. It is of interest that the incidental mortality attending high forceps remains unchanged in the later but much smaller series.

The incidence of mid-forceps has changed but little. The procedure has been relatively safe in the clinic's hands, but still is attended with a high fetal mortality.

The choice of an abdominal route for delivery versus vaginal delivery should include consideration of a number of factors. The excellent maternal mortality and fetal mortality rates which have attended low cesarean section in this clinic have justified our more frequent use. Yet men in this clinic are trained to perform it properly. I feel, however, that the late sequelae even of the low cesarean section, including symptoms of adhesions and mortality from subsequent sections, have not been properly presented in the literature. They should be kept in mind when determining whether to attempt vaginal or abdominal delivery. Vaginal relaxations, with necessary operative repair work of course, are frequent sequelae following instrumental deliveries.

VERSION AND EXTRACTION

Delivery by version and extraction has never been a favorite procedure in this clinic. In the 10,708 cases it has been used in only thirty-eight, and only when indication for immediate delivery was compelling. Transverse, face and brow presentations, prolapsed arms, and prolapsed cord furnished such indications in the presence of contra-indication for cesarean section. Two maternal deaths followed, both in relatively desperate cases. One died on the table with a ruptured uterus. The other died from a paralytic ileus a few days later; the chance that peritonitis was the cause of death was excluded by partial autopsy. Fifteen stillbirths occurred among the thirty-eight deliveries.

BREECH DELIVERY

Three hundred and sixty-eight breech deliveries, an incidence of 3.48 per cent, were conducted without maternal mortality, but with an uncorrected gross fetal mortality of 12.3 per cent. All antenatal fetal deaths, macerated fetuses and neonatal deaths due to prematurity are included in this percentage.

TOXEMIA OF PREGNANCY

Four hundred and eighty-one patients, or 4.5 per cent of the total material, developed a hypertension of more than 150/100 millimeters of mercury, along with varying degrees of albuminuria and edema, and are classified together as non-convulsive toxemias of pregnancy. There were thirty-three other cases which had convulsive toxemia or eclampsia. A follow-up study on this group of cases is at present being carried out and will form the basis for a subsequent report. The fact that nearly 5 per cent of all obstetric cases presented as toxemia of pregnancy warrants attention.

The basic plan of treatment for toxemia of pregnancy in this clinic has been along definitely conservative and accepted lines. Each case, however, is individualized. Cesarean section has occasionally been performed when the toxic manifestations are not convulsive and have failed to respond to conservative treatment. It has not been performed in the presence of convulsions.

There were four maternal deaths among the 481 nonconvulsive toxemias. One woman, who had a very mild toxemia, died from sepsis, developing after her uterus had been packed to control a marked postpartum hemorrhage. Another died from a severe nephritis. A third patient died undelivered in the fifth month from acute yellow atrophy of the liver. The fourth died in the sixth

TABLE 4.—Two Hundred Sixty Mid- and High Forceps

	Period	Number Cases	Incidence	Maternal Mortality	Fetal Mortality
High forceps	1916-1926	54	1.09%	7.4%	38 %
	1927-1937	13	.22%	7.7%	23 %
Mid-forceps	1916-1926	91	1.84%	0	7.7%
	1927-1937	102	1.77%	1.0%	9.8%

month of pregnancy, following vaginal hysterotomy for fulminating preeclamptic toxemia.

There were thirty-seven fetal deaths in the non-convulsive group. The majority were from prematurity when pregnancy was interrupted before term.

There were no maternal deaths and five fetal deaths among the eclamptics. All the fetal deaths were in prematures.

HEART DISEASE

One hundred and twenty-two cases, or a little more than one per cent of the total series, had pregnancy complicating organic heart disease, and were allowed to reach the stage of viability. There were six maternal deaths, or 4.9 per cent mortality. Twenty-four cases, observed in the earlier months of pregnancy, were considered too poor risks from the cardiac standpoint to allow pregnancy to continue to term; in these the pregnancy was terminated by therapeutic abortion.

Sixteen of the 122 became decompensated during late pregnancy, and all of the six maternal deaths occurred among the sixteen decompensated cases.

Eighteen cesarean sections were performed in the group of 122, and fifteen of these sections were primarily for the cardiac indication. In the first series, two decompensated cases were digitalized after medical consultation, and cesarean sections were performed. Both patients died of decompensation during the puerperium.

Since 1928 all cases with cardiac disease complicated by pregnancy have been followed together by both cardiologist and obstetrician. The policy has been to terminate pregnancy early in patients who give a clear history of previous congestive failure. Those who have never had congestive failures are controlled, and their activities properly limited. With the institution of this policy, the mortality rate of former years has been strikingly reduced; but one death has occurred since 1928.

DIABETES AND PREGNANCY

Pregnancy has been a complication of diabetes mellitus in twenty-one patients. There were thirteen spontaneous deliveries, two cesarean sections, and five therapeutic abortions. One maternal death occurred in the preinsulin days, a severe diabetic dying undelivered of a premature infant while in diabetic coma. There were four fetal deaths, including two delivered by the two cesareans, one of which had malformations. The undelivered maternal death and a spontaneous premature delivery complicated by severe toxemia account for the remaining two. Of the thirteen spontaneous deliveries, the average delivered 268 days after the last menstrual period. The average baby weighed 3545 grams compared with the average weight in the clinic of 3478 grams.

TUMORS AND PREGNANCY

Fibroids have not been a particularly serious complication, because there have been few cases with large fibroids. Forty-two pregnancies with fibroids reached the stage of viability. Fourteen

of these had small fibroids, noted at cesarean section performed for indications other than fibroids. In six more cesarean sections, fibroids were part of the indication, but in no case were they given as the sole indication. One myomectomy was done in the fourth month for a four-pound tumor; the pregnancy proceeded to term and a viable child was delivered by cesarean section. Excepting for three breeches (7 per cent), the presentations were cephalic.

Only three pregnancies associated with ovarian tumors have been allowed to go to term. Each of these tumors, including one dermoid, one pseudomucinous cyst, and one single cystoma, were removed at cesarean section at term.

POSTPARTUM HEMORRHAGE

An estimated postpartum blood loss of 600 cubic centimeters or more has been recorded in 230 cases, an incidence of 2.15 per cent. Ninety-eight (43 per cent) of the hemorrhages followed an operative delivery.

Manual removal of the placenta was carried out in fifty cases, though in but twenty-seven of them was hemorrhage the indication. The time factor alone was given as the indication in ten cases; shock or poor general condition in six cases; placenta previa in three cases; no indication given in three cases.

ANTENATAL BLEEDING

It is extremely difficult to determine the exact cause of antenatal bleeding, especially when there is only relatively slight bleeding. In sixty-seven cases, however, bleeding of significant amount was definitely due to premature separation of a normally implanted placenta. In forty other cases the bleeding was due to placenta previa. In the entire group of 107 cases, twenty cesarean sections were performed. Voorhees bags were used to control hemorrhage in twenty-four cases. In recent years, no manipulations or vaginal examinations were carried out in this group of cases until cross-matched donors were available, and preparations for immediate laparotomy were complete. Probably as a result of such precaution, and other improvements in postoperative care, there has been but one maternal death in the 1927-1937 series. On the contrary, there were six deaths during the 1916-1926 series. The death in the later series resulted from puerperal sepsis that followed the use of a bag to control hemorrhage from placenta previa in a pregnancy of six months' gestation.

FETAL MORTALITY

Two hundred and seven fetal deaths occurred after the seventh month of pregnancy in the 1927-1937 series, a gross mortality rate of 3.6 per cent. There were thirty-two macerated fetuses, and eleven babies with very definite malformations. There were also eighty-seven neonatal deaths during the nursery period, sixty of which were in premature infants. Subtracting the macerated fetuses, monsters and neonatal deaths associated with prematurity, leaves a corrected stillbirth delivery rate of 1.8 per cent.

MATERNAL DEATHS

1916-1926	4928 CASES	1927-1937	5780 CASES
SEPSIS	8 CASES	2 CASES	
HEART	4 CASES	2 "	
RUPT. UTERUS	2 CASES	1 CASE	
PARAL. ILEUS	2 "	1 "	
EPID. INFLU.	2 "		
HEMORRH.	2 "	1 "	
TOXEMIA		3 CASES	
DIABETES	1 CASE		
SCARLET F.	1 "		
ANESTH.	1 "		
PULM. EMB.		1 CASE	
PNEUMONIA		1 "	
	23 DEATHS .46%		12 DEATHS .21%

Chart 2

MATERNAL MORTALITY

In the period from 1927 to 1937 inclusive, there were twelve maternal deaths. Two were in nearly terminal toxemia cases referred from outside sources. From a basis of 5,780 deliveries during this period, this gives an uncorrected maternal mortality of .21 per cent, or an uncorrected maternal death rate of 21 per 10,000 deliveries. This compares favorably with twenty-three deaths in the 4,928 cases, a maternal death rate of .46 per cent.

DISCUSSION AND SUMMARY

An improvement in obstetrical management in the University of California Hospital is evidenced by a maternal mortality rate of .21 per cent during the second eleven-year period under study. This rate represents a considerable drop from the maternal death rate encountered in the preceding eleven-year period.

Several of the factors that have helped to bring about the lowered mortality rate have been revealed in this study. An increase in the quality and the duration of prenatal care has reduced the number of cases that entered the Hospital as poor risks and ended in desperate attempt at operative deliveries. As the result of adverse experiences in the earlier years, the various factors which may contribute toward difficult labor are evaluated more closely and earlier. Careful and earlier selection, and preparation of patients for cesarean section, have made it relatively safe in this clinic. As a result, the high maternal and fetal toll in prolonged labors terminated by high forceps, the difficult midforceps, and the versions of former years, are no longer observed. Heart disease complicated by pregnancy is carefully studied and carefully controlled through the coöperation of both cardiologist and obstetrician. Pregnancy is not allowed to continue in the poorer cardiac risks. Deaths from placenta previa and premature separation of the placenta have probably been prevented by careful preparation before institution of treatment.

CONCLUSION

Conservatism in obstetrical management remains the policy of choice, as is evidenced by the .21 per cent uncorrected maternal mortality and the 3.6

per cent uncorrected and 1.8 per cent corrected fetal mortality obtained in 5,780 cases, and this in a teaching hospital. There were 80.5 per cent spontaneous, 3.2 per cent breech, and 16.3 per cent operative deliveries, including low, mid- and high forceps, versions, and cesarean sections.

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DISCUSSION GROUPS AS AN ADJUNCT TO PSYCHOTHERAPY*

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AND

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TODAY a paradox exists in psychiatry. Although a steadily increasing number of psychoneurotic individuals seek treatment, a steadily decreasing proportion of them receive the benefit of modern advances. This state of affairs has been brought about because the trend in psychotherapy has been toward the adoption of procedures necessitating the expenditure of an increasing amount of time with each patient. Utilizing the old-fashioned symptomatic psychotherapy, a single psychiatrist could take care of a large number of patients. With modern time-consuming procedures, comparatively few patients can be treated; therefore costs are high.

If means can be devised whereby several individuals can be given treatment simultaneously, the time, and, therefore, the economic obstacles to the modern approach can in part be overcome. With this end in view, during the past two and a half years we have been employing a form of group reëducational psychotherapeutics as a supplement to personalized psychotherapeutic procedures.

The idea of applying psychotherapy simultaneously to a group of individuals is not new. In the limited time at our disposal we shall not go into the history of various methods that have been employed, but instead shall describe the method we have evolved and have found particularly successful in the treatment of selected cases.

MATERIAL

During the past two and a half years we have conducted 260 discussion groups of one hour each. Fifty-six patients have attended a varying number of such sessions, averaging nineteen per patient. The age range has been from twenty to seventy, with 90 per cent between twenty-five and forty-five

* Read before the Neuropsychiatry Section of the California Medical Association at the sixty-ninth annual session, Coronado, May 6-9, 1940.

years of age. Each group has contained both sexes, all American-born and white. The range of educational background has been from one who failed to complete the sixth grade in grammar school, to professional people with advanced college degrees. The economic status varied from a clerk with a salary of \$100 per month to an individual with a private income of \$30,000 per year. The occupations included most of the usual ones of the Pacific Coast region. No attempt was made to assign patients to groups on the basis of age, sex, economic, educational or social background, but some attention was paid to the general intelligence level.

METHOD

The patients meet once each week at a convenient time after regular office hours. We usually advise them to bring the individual most concerned with their problems; for example, the husband accompanies the wife when the latter is the patient. We have found that ten to twelve people is the optimal size for a group. A fewer number usually means less group spirit, and in a larger gathering the timorous individual is frightened. Every effort is made to keep the meeting informal but dignified, and to avoid direct reference to the specific problems of those present.

Every patient is carefully studied before he joins the group, and personal conferences are held with him throughout the course of the therapy.

At the beginning of the first meeting of the group the psychiatrist emphasizes that he is to act as a leader only because of his specialized training. It is made clear that each one present is to take an active part in the group discussions so that all, working together, may achieve a clearer understanding of human behavior.

The first two group sessions are spent by the leader in bringing out each member's opinion of the factors considered by him to be important in an evaluation of an individual's makeup. All the members are encouraged to enter into the discussion, and their ideas, expressed in their own words, are listed and arranged in a systematic outline. It is then found profitable to present for discussion a simple case history. The outline devised by the group is utilized for a study of the patient and his reactions. The case presentation is prefaced by a statement that, without altering essential factors, some details of the history have been changed so as to make identification of the subject impossible. One selects a case history in which the mechanism of the development of symptoms and the therapeutic approach can be readily understood. With the added encouragement derived from the successful solution of one problem, the group is receptive to a more complete study of the individual.

At this point a general analysis of the causes of biologic behavior, interpreted in the light of environmental influences acting through conditioned reactions, is the most useful method of stimulating further discussion.

A brief explanation of the form and function of the nervous system follows, and an exposition of the interrelationship of the emotional responses

of the individual to his physical condition as a whole.

We have found it advisable next to outline the development of the early years of an individual's life as interpreted from the standpoint of psycho-analytical concepts. We frequently remind the group that in presenting any viewpoint the psychiatrist is neither advocating nor condemning it. It is emphasized that he considers no one viewpoint is adequate for a complete interpretation of human behavior. An outline of psycho-analytical concepts is always of interest and productive of much discussion, which is the primary purpose of the psychotherapeutic group. Elementary psycho-analytical terms are introduced. Oral and anal erotic traits, the Edipus conflict with the attendant castration fears, ego cathexis, fantasy cathexis and object cathexis, are defined and discussed. We use the commonly accepted terminology, and in all discussions bodily parts and functions are spoken of with the utmost frankness. No attempt is made to avoid any details. Experience has shown that if this course is not followed there is an exaggeration of repressions and inhibitions which will at once be manifested by a lack of responsiveness in the group as a whole. This didactic method seems to be unavoidable, but should be limited as much as possible and should be frequently interrupted so as to encourage discussion. Four or five hours is as a rule ample time to lay the groundwork for a talking knowledge. Progress will at once be evidenced by a renewed discussion of previously presented cases and incidents personally observed by members of the group. This is always a favorable sign, but the conductor of the group must see to it that no member is permitted to monopolize the discussions or to remain passive.

At this stage one can expect the overt homosexuals, especially of the aggressive type, to drop out of the group. We have found it impossible to keep such individuals attending without greatly retarding the development of the other members.

As soon as the psycho-analytical viewpoint is made clear, and it is evident that the group is able to make some use of it in their thought processes, a case or two taken from the literature, illustrating the simple concepts of oral erotic and anal erotic character traits, serve as ideal material for discussion. No attempt is made to study any such material exhaustively. Since the purpose of the group is to encourage an objective consideration of the problems of human behavior, it is unnecessary to attempt a complete analysis of cases. However, the group must be urged to go into a case to the fullest depths their knowledge warrants. During the discussion of the psycho-analytical cases material the psychiatrist leading the group seizes such opportunities as present themselves to point out environmental influences and to bring them up for discussion.

It is usually a simple matter to lead the discussion from psycho-analytical concepts to psychobiological ones, special stress being laid upon environmental influences.

The group is then encouraged to examine the environment in the same systematic way that it

TABLE 1.—*Results of Group Reëducational Psychotherapy in Fifty-Six Patients*

Diagnosis	Number of Cases	Results					
		Much Improved		Improved		Unimproved	
		Number	Per Cent	Number	Per Cent	Number	Per Cent
Schizophrenia	2					2	100
Overt homosexuality	2					2	100
Constitutional psychopathic inferiority (character problems)	4			3	75	1	25
Latent homosexuality	9			9	100		
Chronic alcoholism	2					2	100
Sexual perversion	1			1	100		
Sexual impotency (male)	1	1	100				
Compulsion neurosis	2			2	100		
Anxiety neurosis	5	2	40	2	40	1	20
Conversion hysteria	6	3	50	2	33	1	17
Neurasthenia	11			6	55	5	45
Mixed neurosis	11	1	9	8	75	2	18
	56	7	13	33	57	16	30
Normals	9						

examined the individual personality, and in the same manner a list is made of the factors which each person considers important. Here again we have found it necessary to interject a few didactic lectures.

The evidence of environmental influences is presented from the fields of general human ecology, geography, geology, ethnology, anthropology, and history of human customs. As illustrative of the influence of environment upon human beings, one can point out the well-known contrasting customs of the plains people and the mountain people. It is useful to have a globe of the world in the room, together with maps showing the distribution of various environmental factors, such as isothermal maps, maps of rainfall, prevailing winds, plant distribution, etc. We have found that few patients maintain a sustained interest in an analysis of the environment without considerable encouragement; so maps, working models, and diagrams are essential. Illustrative examples drawn from history of the settlement of the United States, and especially local conditions with which the patients are familiar, are important details to be analyzed.

Whenever possible, cases or examples that have come to the knowledge of the members, with the exception of their own personal problems, are used to illustrate the points under discussion. In addition, cases that have been previously presented from other standpoints are reëxamined in the light of the psychobiological interpretation, and efforts are made to encourage the group to weigh and correlate all viewpoints.

As soon as the group can correlate the individual environmental factors, the make-up of the individual himself and his reactions, the members usually express an interest in sociological problems. They are encouraged to bring in questions for discussion, and each member of the group states his opinion as completely as possible.

The physician must always watch carefully for opportunities to present aspects of problems that are similar to personal ones of members of the group; never, of course, directly addressing the individual concerned, or in any way being obvious. In this manner not only is valuable information obtained, by observing the individual's immediate response and his reaction to his problems as disclosed in the private sessions, but indirect suggestion can be administered with ease.

A most helpful spirit of coöperation is developed on the part of whatever relative may have attended with the patient, both in encouraging the patient to continue the investigation of his own difficulties and in modifying environmental factors.

We have found that outlets for the patients, quite aside from the weekly meetings themselves, are increased. Invitations are accepted to join athletic or social groups already established by some member, or descriptions of activities stimulate the retiring ones to try them.

RESULTS

Table 1 gives a brief summary of the clinical diagnoses and final results of the series reported. "Much improved" is defined as those patients who were freed from all their original complaints and who consider themselves completely well. In addition, it is evident to the psychiatrist that the environmental adjustment is within normal limits. Because no case in this group has been followed for more than two and one-half years, we have not classified these patients as "recovered." "Improved" is defined as those cases who were freed of their original complaints, but were not normal in their environmental adjustment. Although some of the "unimproved" group received some benefit they still possessed their original complaints, and their total environmental adjustment was not normal. A small proportion of this group would be listed as "improved," or "much improved," were

we reporting results of other forms of therapy tried after it was decided to dismiss them from the discussion groups. The classification, "normals," includes physicians and other professional people who attended the groups for educational purposes.

As might be expected, one patient suffering from schizophrenia, paranoid type, seemed to be made worse by the discussion groups. The other case of schizophrenia mentioned appeared to show benefit for a few months, but refused to return to the groups and several months later experienced a re-activation of his symptoms. We have listed him as unimproved.

Aside from any direct benefit that might be said to be due to the discussion groups themselves, there was, with one exception, a marked change in the attitude of both the patients and their relatives toward psychotherapy in general. They became more frank, more coöperative, more tolerant of temporary set-backs, and less prone to demand immediate symptomatic benefits. Therefore, supplemental psychotherapy, whether given during the same period as that of group attendance or subsequently, becomes much easier. This increased willingness to coöperate with the physician, and to accept some of the responsibility for the solution of personal problems, seems to parallel the development of group spirit. Members of the group are taught from the beginning to accept responsibility, not to remain passive. Disregarding all other considerations, this change in the attitude of the patients and their relatives makes the discussion groups well worth while. Some of the patients in this series could not have been treated by individual methods alone. They reacted favorably only to group therapy, or to the administration of treatment after attending the discussion groups.

SUMMARY AND CONCLUSIONS

A method of giving psychoneurotic individuals treatment in groups has been described. The results compare favorably with those of other psychotherapeutic methods which have been published.

The advantages are: Adequate therapy can be given to those who cannot afford frequent individual office visits.

Many employed people can be seen without interfering with their regular hours of work.

Reëducation of relatives and friends can be done simultaneously with the patients' psychotherapeutic régime.

The patients obtain practical experience in group adjustment and learn to accept responsibility for solution of problems.

The psychiatrist has an opportunity to observe the patient in a social situation.

Indirect suggestion can readily be given.

Professional people, such as doctors, can be treated more easily than by other methods.

The group spirit which develops carries the individual over temporary set-backs.

Patients are aided in starting outside activities.

490 Post Street.

CLINICAL NOTES AND CASE REPORTS

EQUINE ENCEPHALOMYELITIS

A CLINICAL STUDY OF A SMALL OUTBREAK

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BEING the case histories of four proved cases, one probable case and one case of encephalitis lethargica occurring in the same hospital in the same relative period of time.

Horse encephalitis is not an uncommon disease in the San Joaquin Valley. Horse encephalitis in humans, in the limited experience of the authors, does not seem uncommon either.

Evidently a central nervous system disease, with unusual onsets, unusual symptom and sign complexes, it leads to a follow through on these cases, with a resultant positive diagnosis.

Anterior poliomyelitis, encephalitis lethargica, equine encephalitis, and benign lymphocytic meningitis, were all considered as diagnosis in these cases. Positive diagnosis was made through Dr. Karl Meyer at the Hooper Foundation by means of specific blood reactions made at the Foundation.

The four proved cases—the one probable case and the one case of encephalitis, St. Louis type—are given to show the similarity in common findings and the difficulty of diagnosis without specific laboratory aid such as that obtained at the Hooper Foundation.

REPORT OF CASES

CASE 1.—White male, age 15.

C. C.—Headache, backache, soreness in neck and malaise four days. Weakness in right leg one day.

P. I.—Four days before entry he went to a moving-picture show, and on leaving had a headache which continued unabated. Since, he had gradually developed soreness in the neck, and backache. The day before entry bladder paralysis developed, coupled with weakness in right leg. He lived on a farm where two horses, which had not been sick, were used.

P. E.—Positive findings of distended bladder—up to umbilicus. Right arm and forearm questionably weak. Paralysis of right leg, complete in both flexor and extensor groups. Reflexes were normal on left, decreased on right and absent in right leg.

Temperature on entry, 102 degrees; pulse, 104; respiration, 20.

On the third hospital day the temperature, pulse, and respiration gradually fell to normal and remained so. Bladder function returned, and there was a slight improvement in right leg weakness.

Laboratory:

First Day.—Spinal puncture on entry: fluid was clear; pressure, 196 millimeters of water. Cell count, 138; 99 per cent lymphocytes.

Second Day.—Cell count, 25; 95 per cent lymphocytes; spinal-fluid sugar, 71 milligrams per 100 cubic centimeters of fluid.

Third Day.—Cell count, 78; 96 per cent lymphocytes.

Fifth Day.—Cell count, 20; 100 per cent lymphocytes.

Sixteenth Day.—Cell count, 12; 100 per cent lymphocytes.

Urine: On entry, urine was negative. Developed cystitis during catheterization, which had cleared on discharge from hospital.

Blood: Was negative for St. Louis type of encephalitis, and positive for equine encephalitis.

On discharge, could not lift right heel off bed.

CASE 2.—White male, age 19.

C. C.—Pain in left chest for eight days. Chills for one.

P. I.—Eight days before entry, while climbing stairs, he had sudden sharp pain in chest, with dyspnea. Pain continued, but not severely enough to keep the patient from work. A chill the night before entry forced the patient to bed.

P. H.—Patient had come to California from Tennessee a little over two months before entry, and had been working on ranches in the San Joaquin Valley. For the past two weeks had had a job in a hay-field, working with four horses, none of which were sick.

P. E.—First Day: Physical examination was negative except for chest, where friction rubs were heard at both bases on entry. Breath sounds were normal. The patient was having much chest pain, although chest plate was negative.

Second Day.—Complained of headache and pain in back. Diaphoresis was profuse. Developed bladder paralysis and had to be catheterized. Spinal puncture was done. On the fourth hospital day, bladder function returned. Patient's temperature, which was 104 degrees on entry, came down by lysis to normal on the fifth hospital day. However, the patient ran a daily elevation, at times as high as 101 degrees, until five days before discharge on the twenty-ninth hospital day.

Pleural friction rub heard on the first day was not heard on the second day. Soreness and stiffness of neck found, and suggestion of Kernig's present on second day.

Laboratory:

Spinal on second day: pressure, 150; fluid clear; cell count, 2; 1 lymphocyte; sugar, 67 milligrams.

Third Day.—Cell count, 3; all lymphocytes.

Sixth Day.—Cell count, 21; 97 per cent lymphocytes.

Eighteenth Day.—Cell count, 16; 100 per cent lymphocytes.

Wassermann was negative.

On entry: Hemoglobin, 75; white blood count, 15,100; 77 per cent polymorphonuclears.

Blood serum was positive for equine encephalitis, and negative for the St. Louis type.

CASE 3.—White male, age 22.

C. C.—Headaches.

P. I.—Entered hospital with no other complaint but persistent headaches and malaise.

P. E.—Physical examination revealed soreness of neck without true rigidity. There was a suggestion of Kernig's and bladder paralysis on entry. Examination was otherwise negative, and bladder function returned on second day. Headache persisted for nine days after entry. Temperature on entry was 101.6 degrees, pulse 108, respiration 22. On ninth hospital day temperature hit normal, to remain.

First Day.—Spinal on entry: fluid clear, cell count, 9; all lymphocytes.

Third Day.—Cell count, 55; 95 per cent lymphocytes.

Seventeenth Day.—Cell count, 37; 97 per cent lymphocytes.

Urine was negative.

Spinal fluid was negative for both equine and St. Louis type of encephalitis.

CASE 4.—White male, age 37.

C. C.—Since tonsillectomy, three weeks before entry, for peritonsillar abscess, had been getting weak, and for three days before entry had chills and fever. Past history of working two horses on truck farm, which was infested with mosquitoes.

P. E.—Patient looked toxic and was sweating profusely. His throat was well healed. Some râles were heard at the base of the left lung. Heart was negative. No stiff neck nor Kernig's present.

Course: On second hospital day the patient complained of soreness in his neck and a headache. He was sleepy and took nourishment poorly. Headache persisted up to the tenth day, with no complaints from that day to discharge on the twenty-first day.

Temperature on entry was 103.6 degrees, but fell abruptly to normal on the second evening and remained so for the

rest of his hospital stay. The pulse was consistently slow (between 60 and 80) except on entry, when it was 108 degrees. Respirations were 26 on entry, but as soon as the temperature reached normal, respirations fell to 16 and 18.

Laboratory: Urine negative, Wassermann negative.

Spinal fluid on third hospital day showed 107 cells with 97 per cent lymphocytes.

White blood count on sixth hospital day was 9,900 with 73 per cent polymorphonuclears and 6 per cent eosinophils.

Spinal fluid on seventh hospital day showed 111 cells with 98 per cent lymphocytes.

Blood was positive for equine encephalitis, and negative for St. Louis type.

CASE 5.—White female, age 32.

C. C.—Chief complaints on entering hospital were frontal headache for four days and drowsiness for two days. Family and past history had no bearing on present illness.

P. I.—Patient was working in peaches when she started to complain of headache, which became worse next day. On the third day of illness, she complained of being sleepy and from that time on remained in bed. On the fifth day she was stuporous and became irrational in the evening. On the sixth day she entered the hospital. There was no history of proximity to horses.

P. E.—Young female lying in bed; restless and irrational. Pupils equal and react to light. Examination of fundi impossible, because of mental condition of the patient. Oral examination, normal. Chest was clear. Heart normal. Blood pressure, 102/84 and of poor quality. Abdominal examination was negative. No muscle weakness noted. Reflexes were equal and active. Suggestion of Kernig's present. Spinal puncture revealed clear fluid under pressure of 140 millimeters of water, and 247 cells found, of which 95 per cent were lymphocytes.

White blood count, 10,100; polymorphonuclears, 77; lymphocytes, 23.

Sedimentation time was 23 millimeters fall in one hour.

Urine showed a trace of albumin, with a few granular casts.

Spinal puncture on the fourth hospital day revealed clear fluid under 180 millimeters of water, and there were 80 cells in spinal fluid, of which 97 per cent were lymphocytes. Spinal fluid sugar was 68.8 milligrams.

Wassermann was negative.

Spinal fluid was positive for horse encephalitis, and negative for St. Louis.

The temperature came down from entry level of 102.8 degrees by lysis to normal on the fourth hospital day and remained so. The pulse came down from 120 to 80.

Course: Patient was irrational on entry and had to be catheterized the first two days in the hospital. On the fifth day she became cognizant of her surroundings. At about this time she started to complain of nausea and dizziness. A slight nausea persisted up to the time of discharge. At the time of discharge the patient was nervous and had the suggestion of a "Parkinsonian mask."

CASE 6.—White female, age 15.

C. C.—Pain in the back and left side, one day; headache, one day; weakness in arms and legs, one day.

P. H.—Patient had been living in fig camp for one week, where two horses were used.

P. I.—On morning of entry, the patient had a sudden onset of pain in the left flank and back, with a slight headache. About an hour later a gradual weakness of arms made her unable to lift them. In the afternoon her legs began to weaken. Last B. M. at 9 a. m.

P. E.—Patient's speech was thick, although palate was normal. Bilateral weakness of deltoids, biceps and all other upper extremity muscles completely out. No headache or neck stiffness. Bladder was distended to umbilicus. Complete flaccid paralysis of lower extremities. Kernig's were negative. Patellar reflexes were absent. Incontinent of feces. The patient continued worse and never regained bladder control. Paralysis progressed to involve intercostal muscles.

Patient had two convulsions on the morning of the eighth hospital day, and died during the third convulsion.

Temperature on entry was 103.4 degrees; pulse, 100; respiration, 20.

Temperature remained high the first three days: 104

degrees; 105 degrees; down to 101 degrees, then 105 degrees at the time of death.

Spinal punctures: On entry, fluid clear; pressure, 110 millimeters of water; found 3 cells; 1 lymphocyte; sugar, 72 milligrams.

Third day: One cell; lymphocyte.

Blood: Wassermann was negative.

Red blood count, 3,490,000; 65 per cent hemoglobin.

White blood count, 14,350; polymorphonuclears, 79.

On entry: Hemoglobin, 72 per cent; white blood count, 12,750; urine was negative.

Blood was positive for St. Louis type of encephalitis, and negative for equine encephalitis.

COMMENT

From the foregoing, it would seem that the diagnosis of encephalitis equinus can be only a provisional diagnosis. While the diagnosis may be suspected because of the unusual sequence of events or the picture of a central nervous disease that does not quite fit poliomyelitis or epidemic encephalitis, positive diagnosis rests on available blood reactions.

Bladder paralysis and pain (not stiffness) in the neck were the most constant findings. Frontal headache was also present in most. Suggestive Kernig's were found in most cases.

In review of the cases, the mode of onset varies in every case, *i. e.*, it may be sudden or gradual.

The temperature curve was not the same or at all similar in any two cases, but all had temperature elevations. The white counts varied from 9,000 to 16,000, and the polymorphonuclear percentages varied from 69 to 91.

The spinal fluid cell counts in all cases diagnosed, horse encephalitis varied from 3 cells to 247 cells, but in no one case was the highest cell count less than 21 cells.

The one case of St. Louis type encephalitis showed three cells on first spinal, and one cell on subsequent spinal.

The differential spinal fluid cell count was always 95 per cent, or over, lymphocytes, including the encephalitis lethargica.

Spinal fluid sugar in all cases was normal.

Blood serums as reported by the Hooper Foundation were either positive for encephalomyelitis equinus or St. Louis type, never for both. In one case the report was negative for both types. This case occurred while two other cases of horse encephalitis were in the hospital; the picture was very similar and diagnosis was made in spite of negative blood finding at the Hooper Foundation.

SUMMARY

Encephalomyelitis equinus is not an uncommon disease, especially in the San Joaquin Valley. The disease may easily be mistaken for anterior poliomyelitis or encephalitis lethargica. In the cases presented, physical finding of bladder paralysis, soreness of the neck, frontal headaches, and suggestive Kernig's were most constant. Spinal fluid cell count varies widely, but lymphocytes are always predominant, while spinal-fluid sugars are always normal.

All areas of Merced County, from which these cases came, were heavily infested with mosquitoes, while about 50 per cent of the patients had no contact whatever with horses.

Arroyo Del Valle, Livermore.
Merced General Hospital.

A NEW TYPE OF BELT FOR SPLINTING THE CHEST*

By ROBERT A. STEVEN, M. D.
San Francisco

RECENTLY I designed a new type of belt for use in unilateral pleurisy or rib fracture, consisting of strong elastic for the sound side of the chest, and material for the side involved. One shoulder strap prevents the belt from sliding down. On to each end of one-half are sewed three long canvas straps, and on to each strap is threaded a strong eye which can be looped over hooks sewed onto the ends of the opposite half. By pulling on the straps the belt can be tightened both in front and behind.

One might think that a belt containing elastic in any part of it would allow both chests to expand equally, but this is not the case. I tested the belt first on a patient with fracture of the right seventh rib. With the belt in place the breath sounds on the right side above and underneath the belt were greatly diminished, but were normal on the left; whereas, when the belt was off the breath sounds were plain on the right, proving that the diminution of breath sounds in the first instance was not due to natural splinting following a fracture. Also, we viewed the chest under the fluoroscope with the belt in place, and the movement on the right was greatly restricted. The explanation for this fact is that friction between the skin and the belt prevents the belt from sliding, and therefore only the elastic side allows chest movement.

I have used the belt both in pleurisy and rib fracture, with relief of pain in both. The advantages over adhesive need no comment.

Other belts for splinting the chest are on the market, but they contain a strip of elastic on each side, allowing equal, though restricted movement of the two sides. An elastic bandage wrapped

* From the Department of Medicine, University of California.

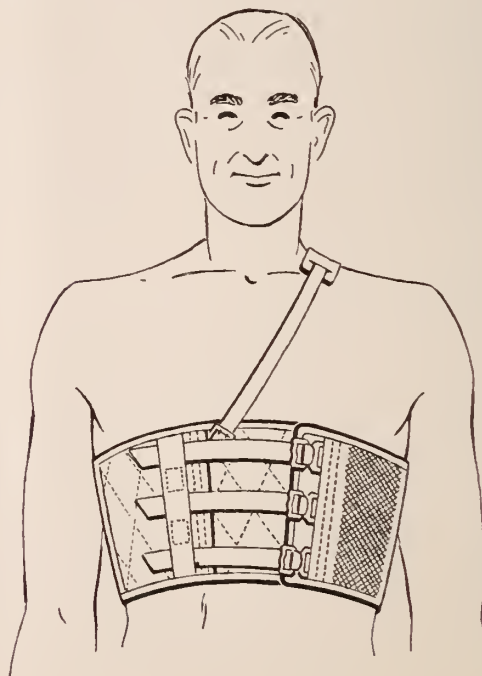


Fig. 1.—Elastic belt for splinting chest.

around the chest accomplishes the same purpose as these belts, although it will not stay in place as well.

When using the belt on a woman, it is placed as high up under the breasts as possible, but not overlying the breasts. I used one recently on a very obese woman having large pendulous breasts, with complete relief of pain. The application of adhesive on such a chest is virtually impossible.

It has been suggested to me that one might use this belt also to secure desired expansion of one chest, as, for instance, following empyema, etc., by making the belt with the elastic only on the involved side, thus encouraging expansion of this side, while restricting movement on the side that is good.

The first belt was kindly made for me and furnished by the David Fox Surgical Appliances. The illustration is theirs. The belt is usually about eight inches in width. Two measurements are necessary; the circumference at the level desired for the upper border of the belt, and the circumference eight inches below this level. The retail price of this belt should not exceed \$10. A sample belt, if measurements are given, can be obtained from the David Fox Surgical Appliance Co., 319 Mason Street, San Francisco, for the price quoted. The belt in place is illustrated in Figure 1.

384 Post Street.

HIPPOCRATES' APHORISMS*

By M. SCHOLTZ, M. D.
Arcadia

SECTION THREE

1. Changes and variations of the seasons
Are common factors leading to disease;
Transitions from a hot to chilly weather
Prepare the soil for illness with great ease.
2. Some people's nature craves more summer
heat,
While others winter snow and cold entreat.
3. Diseases and the ages are related
To seasons, types of food and to locations;
This fact determines whether these two factors
Are suited well or ill in combinations.
4. When daily weather changes
From hot spells to cold,
Some morbid visitations
May be foretold.
5. South winds induce hard hearing and dim
vision,
Dull head and languor; while the north winds
cause
Hard bowels, sore-throat, dysuria with chills,
Coughs, pains in chest and breast and kindred
woes.
6. When summer is like spring, replete with
humid air,
The fevered sick excessive sweating bear.
7. The droughty summers,
With dry, torrid breezes
Are likely to bring on
Acute and fell diseases.
8. When seasons follow the pattern set by nature,
And weather runs true to a season's norm,
Diseases also run according to their patterns,
And crises come within time-limits of the
norm.
9. In fall, diseases are
More fatal and acute;
In spring, they're more benign
And easier to uproot.
10. Fall is a bad season for the sick with phthisis.
11. If winter's dry, with northern winds pre-
vailing,
And spring, swayed by the southern winds,
is wet;
Then summer brings on sore eyes, dysenteries,
And agues, in humid people mostly met.
12. If winter's rainy, calm, with southern winds,
And spring is dry, and winds blow from the
north,
Then pregnant women from the slightest
cause abort,
Or withered feeble infants are brought forth.
Withal crop up sore eyes and dysenteries,
And the old men fall prey to nose catarrhs.
13. If summer's dry with northern winds pre-
vailing,
And southern winds supply much rain in fall,
Then winter sows headaches, coughs, corizae
And, in some cases, even phthisis may befall.
14. If fall is dry and winds blow from the north,
With humid men and women this agrees,
But others may fall prey to sore eyes, fevers,
To colds and, in some cases, melancholies.
15. Dry seasons, as a rule,
Are healthier than the wet,
Which are more likely to
Mortalities beget.
16. Rainy seasons bring on chronic fevers,
Loose bowels, quinsies, fits, strokes and
gangrene;
In dry seasons dysenteries, phthisis,
Dysurias, joint and eye troubles are seen.
17. North winds improve the hearing, brace the
body,
But pinch the eyes and aggravate chest pain;
The south winds relax and slow the body,
Dull sight and hearing, and oft load the brain.
18. In spring and early summer the young bloom;
The old folks do the best in summer and early
fall;
While for the people of intermediate ages,
Late fall and winter is the best of all.
19. While all diseases may occur
In any season of the year,
There're some of them that strongly tend
In certain seasons to appear.
20. Diseases of the spring are: colds and coughs,
Bleedings, quinsy, fits and spells of sadness;
Joint-troubles, leprosy and skin eruptions
With ulcers, nodules, and at times, acute mad-
ness.

* For other aphorisms, see CALIFORNIA AND WESTERN MEDICINE, March, 1940, page 125; April, 1940, page 179; May, 1940, page 231; July, 1940, page 35.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HARRY H. WILSON.....President
HENRY S. ROGERS.....President-Elect
LOWELL S. GOIN.....Speaker
PHILIP K. GILMAN.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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7. *California Physicians' Service.*
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9. *Woman's Auxiliary.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS*

State Chairman and Representative

Philip K. Gilman, M. D., 2000 Van Ness Avenue
San Francisco

County Chairmen and Representatives

Alameda County: C. H. Church, M. D., 2082 Center Street, Berkeley.
Alpine County: Max Isoard, M. D., 1127 Eleventh Street, Sacramento.
Amador County: Max Isoard, M. D., 1127 Eleventh Street, Sacramento.
Butte County: J. O. Chiapella, M. D., 131 Broadway, Chico.
Calaveras County: Philip V. Lamb, M. D., Angels Camp.
Colusa County: Benjamin F. Miller, M. D., 439 Central Street, Yuba City.
Contra Costa County: Leopold H. Fraser, M. D., 134 Tenth Street, Richmond.
Del Norte County: Francis M. Stump, M. D., Crescent City.
Eldorado County: Max Isoard, M. D., 1127 Eleventh Street, Sacramento.
Fresno County: H. M. Ginsburg, M. D., Fresno General Hospital, Fresno.
Glenn County: J. O. Chiapella, M. D., 131 Broadway, Chico.
Humboldt County: Charles C. Falk, Sr., M. D., 507 F Street, Eureka.
Imperial County: John L. Parker, M. D., Bank of Italy Building, Brawley.
Inyo County: C. L. Scott, M. D., 609 Elm Street, Bishop.
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Kings County: Charles T. Rosson, M. D., 208 North Douty Street, Hanford.
Lake County: Charles Craig, M. D., Lakeport.
Lassen County: James D. Coulter, M. D., Western Pacific Railway Hospital, Portola.

Los Angeles County: Walter A. Bayley, M. D., 4546 Circle View, Los Angeles.
Madera County: Smith A. Quinby, First National Bank Building, Madera.
Marin County: F. M. Cannon, M. D., Albert Building, San Rafael.
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Mendocino County: Walter Rapaport, M. D., Talmage.
Merced County: Edward A. Jackson, M. D., Atwater.
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San Joaquin County: Arthur C. Boehmer, M. D., 315 West Pine Street, Lodi.
San Luis Obispo County: Fred R. Mugler, M. D., 1170 Marsh Street, San Luis Obispo.
San Mateo County: Carl D. Benninghoven, M. D., Mills Memorial Hospital, San Mateo.
Santa Barbara County: H. J. Ullmann, M. D., 1520 Chapala Street, Santa Barbara.
Santa Clara County: R. Stanley Kneeshaw, M. D., 404 Medico-Dental Building, San Jose.
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Tuolumne County: Henry C. Rixford, M. D., Jamestown.
Ventura County: Arlo A. Morrison, M. D., 705 Main Street, Santa Paula.
Yolo County: J. Homer Woolsey, M. D., Woodland Clinic, Woodland.
Yuba County: Benjamin F. Miller, M. D., 439 Central Street, Yuba City.

†For complete roster of officers, see advertising pages 2, 4, and 6.

* For editorial and other comments, see pages 53, 54, 90 and 100.

CALIFORNIA STATE COUNCIL OF DEFENSE†

Complexion of Local Boards.—Each local board is to consist of seven members as follows: a surgeon; an internist; an eye, ear, nose, and throat specialist; an orthopedist; a neuropsychiatrist; a radiologist; and a dentist.

Cities in Which the Headquarters of the District Boards Are to Be Established.—There will be nineteen district or local boards. In the list which follows, there will be one such board for each of the districts named, with the exception of San Francisco, which will have two separate boards, and Los Angeles, which will have six separate boards: Eureka (1); Redding (1); Sacramento (1); Oakland (1); Napa (1); Stockton (1); San Francisco (2); San Jose (1); Fresno (1); Salinas (1); San Diego (1); Los Angeles (district) (6); and Riverside (1).

Counties Included in the Various Districts.—From a map which was received, the districts, with their city headquarters, are as follows:

1. **Eureka District.** (Headquarters of this district will be in the city of Eureka.) Includes the following counties: Humboldt, Del Norte, and Mendocino.

2. **Redding District.** (Headquarters of this district will be in the city of Redding.) Includes the following counties: Siskiyou, Modoc, Trinity, Shasta, Lassen, Tehama, Plumas, Butte, and Glenn.

3. **Sacramento District.** (Headquarters of this district will be in the city of Sacramento.) Includes the following counties: Sierra, Nevada, Placer, Yuba, Sutter, Colusa, Yolo, Sacramento, and Eldorado.

4. **Oakland District.** (Headquarters of this district will be in the city of Oakland.) Includes the following county: Alameda.

5. **Napa District.** (Headquarters of this district will be in the city of Napa.) Includes the following counties: Napa, Solano, Sonoma, and Marin.

6. **Stockton District.** (Headquarters of this district will be in the city of Stockton.) Includes the following counties: San Joaquin, Stanislaus, Tuolumne, Calaveras, Amador, and Alpine.

7. **San Francisco District.** (Headquarters for this district will be in the city of San Francisco.) Includes the following counties: San Francisco City, San Francisco City.

8. **San Jose District.** (Headquarters for this district will be in the city of San Jose.) Includes the following counties: San Mateo, Santa Cruz, and Santa Clara.

9. **Fresno District.** (Headquarters for these districts will be in the city of San Francisco.) Includes the following counties: Merced, Mariposa, Madera, Fresno, Kings, Tulare, Kern, Inyo, and Mono.

10. **Salinas District.** (Headquarters of this district will be in the city of Salinas.) Includes the following counties: Monterey, San Benito, and San Luis Obispo.

11. **San Diego District.** (Headquarters of this district will be in the city of San Diego.) Includes the following counties: San Diego and Imperial.

12. **Riverside District.** (Headquarters of this district will be in the city of Riverside.) Includes the following counties: Riverside, San Bernardino, and Orange.

13. **Los Angeles District.** Headquarters of these districts will be as follows:

In Santa Monica or Beverly Hills, to handle Santa Barbara and Ventura counties; Long Beach or Compton; Burbank, Glendale, or Pasadena; Los Angeles City or Hollywood; Los Angeles City; Los Angeles City.

C. M. A. COUNCIL

Abstract of the Minutes of the Two Hundred and Eighty-Eighth (288th) Meeting of the Council of the California Medical Association*

Held in Room 309, Sir Francis Drake Hotel, Sutter and Powell streets, San Francisco, Saturday, June 29, 1940, at 9 a. m.

† For editorial and other comment, see pages 53, 86 and 90.

* Complete minutes of the Council are available for inspection to any member of the Association upon request.

1. Roll Call.

All members of the Council were present, except as noted: Speaker Lowell S. Goin, O. D. Hamlin (ill), A. E. Anderson (out of state), Dewey R. Powell (out of state).

2. Chairman of Committee on Public Relations.

A mail vote resulted in the election of Dr. Donald Cass of Los Angeles as chairman of the Committee on Public Relations.

3. Resignation of C. O. Tanner.

Resignation of C. O. Tanner of San Diego, Councilor-at-Large, was accepted with regret and thanks for past services.

4. Election of Councilor-at-Large.

Dr. Sam J. McClendon of San Diego was elected councilor-at-large, until the 1941 annual session, to fill the vacancy caused by the resignation of C. O. Tanner.

5. Minutes of Council.

Minutes of the Council meetings (282nd to 287th, inclusive), were approved.

6. Financial Statements.

Financial statements were placed on file.

7. Expenses of Officers.

Concerning the by-law included under Resolution No. 16 adopted by the House of Delegates at Del Monte in 1939, and relating to expense of officers, it was voted that expense items which were not submitted within sixty days after indebtedness was contracted should not be paid.

8. Woman's Auxiliary Roster.

The cost of the separate roster of the Woman's Auxiliary to the California Medical Association was stated to be \$313.01.

9. Special Assessment of June 1, 1939.

Discussion was had concerning procedure in relation to members who were liable for the special assessment of June 1, 1939, who had not paid the same. It was agreed that a letter should be sent to all such members, urging payment, since the expense of the work inaugurated by the Committee on Public Health Education should be proportionately borne by all California Medical Association members, share and share alike.

10. Publications Committee.

Editor's request for transportation expense for a meeting of the Committee on Publications was approved.

11. California Physicians' Service.

Report was made that the mail vote for an additional loan of \$5,000 had been in favor thereof. It was stated that California Physicians' Service had not found it necessary to ask for the loan, up to date of June 29.

12. Indemnity Defense Fund.

A report on the Indemnity Defense Fund inaugurated in the year 1917, and possible procedure in relation to future custodianship of the funds, was made. It was voted to transfer the custodianship from the group of three trustees to the nonprofit corporation, "Trustees Of The California Medical Association." The former trustees were given a vote of appreciation for their past services.

The Legal Counsel was authorized to carry out the instructions of the Council.

13. Recess.

(To permit meetings of the following organizations):

1. Members of "Trustees Of The California Medical Association" (to elect members of the Board of Directors).

2. Board of Directors of "Trustees Of The California Medical Association" (to elect officers of the Board of Directors).

3. Executive Committee (to elect a chairman of the Executive Committee. Charles A. Dukes of Oakland was elected).

14. Reconvening of Council.

15. Reinstatement of Members.

It was voted that all 1939 members who had paid their dues subsequent to April 1, 1940, be reinstated to membership.

16. Retired Membership.

Retired membership was granted to Robert L. Miller and J. E. Vallee of Los Angeles County.

17. Membership Dues.

Legal Counsel was instructed to prepare an amendment providing for payment of amount less than annual dues, to apply to new members admitted after July 1 of any calendar year.

18. Membership.

Reports were submitted regarding several membership problems.

19. Reorganization of County Medical Societies.

Official names in the reorganized counties of the Eighth District shall be: Butte-Glenn County Medical Society; Yuba-Sutter-Colusa County Medical Society and Yolo County Medical Society.

20. Resolution No. 14—Expert Witnesses.

The Department of Public Relations was requested to study Resolution No. 14, adopted by the House of Delegates at Coronado, and make recommendations thereon.

21. Resolution No. 33—Aid to Needy Members.

It was voted that the present Committee on Aid to Needy Members (A. E. Anderson, chairman, Elizabeth Mason Hohl, and Robert Peers) be continued until the next annual session.

22. Resolution No. 30—County Hospital Fees and Accident Cases.

A special committee, consisting of Doctors Cass, O'Neill, and Reinle, was appointed for this work.

23. Date of Del Monte Annual Session 1941.

Date of the next annual session will depend upon the date of the 1941 session of the American Medical Association. It was agreed that Council Chairman Gilman should confer with President Harry H. Wilson and President-Elect Henry S. Rogers as soon as the date of the American Medical Association meeting is set, and they shall have authority to determine the dates for the 1941 California Medical Association session at Del Monte (probably in May, 1941).*

24. Annual Session Equipment.

The chairman of the Committee on Scientific Program, Doctor Kress, was authorized to purchase additional projection apparatus, view boxes, time clocks, etc., for the twelve scientific sections, so that each section may be provided with proper equipment at the next annual session.

25. Annual Session Programs.

For the Committee on Scientific Work, Chairman Kress requested approval of the plan to continue the general meetings on each of the four mornings of the annual session; to give up the Tuesday afternoon entertainment features to permit scientific sections to hold their meetings on each of the four afternoons; to notify collateral and affiliated

organizations that their meetings must be held on meeting days prior to or subsequent to those of the annual session (owing to the limited meeting-room accommodations).

26. Basic Science Act.

Discussion of possible action in regard to the Basic Science Law was had. It was voted to recommend to the Committee on Public Health Education that it strive to expedite the work of securing signatures and to take other necessary steps for the enactment of a Basic Science Law.

27. Report of Delegates to the American Medical Association.

Delegate Best reported on the recent meeting of the American Medical Association held in New York. Attention was called to the fact that the American Medical Association 1943 session will be held in San Francisco; also that, under the reapportionment of the House of Delegates of the American Medical Association, California will be entitled to an additional delegate, this delegate to be elected at the fall meeting of the Council.

The American Medical Association Committee on Medical Preparedness was discussed by Doctor Dukes, who is a member of the American Medical Association Committee of Ten, and the Council voted that P. K. Gilman of San Francisco be appointed chairman of the California Committee on Medical Preparedness, with power to select district and county representatives to work with his committee in coöperation with the American Medical Association program.

28. Wagner-George Bill, Senate 3230.

It was felt that the proposed Wagner-George hospitalization law now before Congress was not altogether satisfactory; and the California Medical Association Council was in agreement with the opinions expressed by the American Medical Association.

29. Compulsory Health Bill.

It was reported that the proposed compulsory health bill could not be placed upon the ballot of the November, 1940, state election, but that it would probably be submitted to the California Legislature in January, 1941.

30. Legislation.

Mr. Read called attention to the amendment to the Relief Bill passed at the special session of the California Legislature whereby it would be possible for California Physicians' Service to coöperate in giving medical care to citizens of certain income groups.

Attention was also called to the fact that the primary elections for legislative candidates would be held on August 27, and the importance of physicians being alert to their civic obligations was stressed.

31. Committee on Public Health Education.

Mr. Marshall made a report on the status of the Essay Contest, and on other activities of the Committee on Public Health Education.

32. Doctors' Day.

It was stated that the American Medical Association had taken no action thereon.

33. Resolution No. 2—Basic Hospitalization Cost.

It was voted that Resolution No. 2 be referred to the California Medical Association standing committee on Hospitals, Dispensaries and Clinics, J. Normal O'Neill, chairman.

34. Resolution No. 23—Proposed Pound Law.

It was voted that Resolution No. 23, in relation to unclaimed dogs in pounds, be referred to the special committee of which Dr. P. K. Gilman is chairman.

* Date has since been set as May 5-8, 1941.

35. Resolution No. 24—Traffic Exemptions to Physicians.

Resolution No. 24, relating to exemption of physicians from traffic laws, was referred to the California Medical Association Legal Counsel for study and report.

36. Speakers' Bureau.

It was announced that Dr. Charles A. Noble of San Francisco had been appointed chairman of the Northern Division of the Speakers' Bureau, to take the place of Dr. John W. Cline, resigned.

37. Publication of Nevada Papers.

The problem of publication of papers read at the annual session of the Nevada State Medical Association was discussed.

38. Members' Endowment Fund.

The donation received from Dr. Brett E. Davis was placed to the credit of the Members' Endowment Fund.

39. Medical Preparedness.

A report was made concerning the need of physicians to aid in the medical care of civilians in the British Isles.

40. California Federated Athletes' Association.

Concerning fees established by the California Federated Athletes' Association, it was voted that this matter be referred for consideration to the Committee on Industrial Medical Practice.

41. Recess for Luncheon.

42. Reconvening.

43. Expert Witnesses.

Legal Counsel Peart discussed certain phases having to do with expert witnesses.

44. Goodall vs. Brite.

Legal Counsel Peart reported concerning this case.

45. Smith vs. Kern County Medical Society.

Legal Counsel Peart reported concerning this case.

46. Council Meeting.

It was voted that the next meeting of the Council be held at Los Angeles on Sunday, October 6, 1940.

47. Executive Session.

Executive session of the Council was called to order by Chairman P. K. Gilman, John W. Cline acting as secretary.

(a) Report was made by President Harry H. Wilson on reorganization plans.

(b) Pension of \$40 per month, subject to revision from time to time, granted to Miss Bradford.

(c) Salary of secretary-treasurer was fixed at \$300 per month.

(d) A special committee was appointed to submit to the Council plans for possible revision of standing and special committees as basis for report to the House of Delegates in 1941. (Chairman Gilman appointed as committee: Doctors George D. Maner, R. Stanley Kneeshaw, and Elbridge J. Best.)

(e) Minutes of the Council to be no longer printed in full in the OFFICIAL JOURNAL, but instead an abstract only with statement, "Complete minutes of the Council are available for inspection to any member of the Association upon request."

Councilors to continue to receive mimeographed copies of minutes and galley proofs of the abstracts.

(f) A special committee, consisting of President Harry H. Wilson, President-Elect Henry S. Rogers, and Chairman P. K. Gilman, was appointed to interview candidates for the new position in headquarters office, and make recommendations to the Executive Committee in regard to the candidates. California Medical Association Executive Committee to have power to appoint and to determine the salary.

Prior to any appointment being made by the Executive Committee, informative data concerning the various candidates to be submitted to the members of the Council.

48. Adjournment.

P. K. GILMAN, *Chairman.*

GEORGE H. KRESS, *Secretary.*

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Direction of the campaign to enact a Basic Science Law in California was assumed by the Committee on Public Health Education during the past month.

At the request of the Council, and pursuant to instructions voted by the House of Delegates at Coronado, the Committee took the first steps toward securing this legislation, which has been desired by the medical profession over a long period of time.

Every member of the California Medical Association will be asked by the Committee to do his or her share toward accomplishing this desirable objective with the utmost efficiency and the least cost.

At the present, activities are with the legal department, preparing the exact form of the measure, which must be enacted as an initiative by vote of the people. The draft of the Special Committee on Basic Science Law, as revised by the Committee on Public Relations last year, will again be carefully studied and further revised. When the proposed act has been properly titled by the Attorney-General and the petitions for circulation among the voters have been prepared, members will be advised of the manner in which they can help in this undertaking.

The Committee on Public Health Education reports progress both on the essay contest now open to students in high schools and junior colleges and on the motion picture, which will depict the advance of medical science in the manner calculated to most appeal to the public.

In anticipation of a busy season starting after the vacation period, the Committee is urging intensified efforts on the part of all speakers' bureaus and additional organization of the same. The Committee also has launched efforts to increase the radio programs now being devoted to medical speeches, which through the coöperation of various county societies have been made available at little or no cost to the medical profession.—R. M.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Goin, Los Angeles; Junius E. Harris, Sacramento; Dewey R. Powell, Stockton; Harry H. Wilson (ex officio), Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUCKER 2312), or 244 Kearny Street, San Francisco (telephone YUKON 2212).

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Health and Medical Preparedness*

The problem which concerns each of us today is what we can do to contribute to the safety of our country. Traditionally, as doctors and nurses, we have been servants of peace. When war did come, it was our job to patch up the wounds, ease the suffering of the wounded, and repair as best we could the damage done by shot and shell.

We are not at war. If we have time enough—if we are swift and wise enough in the time that we have—war in this hemisphere may be prevented. But the old rules of war, and the preparation for it, have been demolished. The whole task of national defense is different from what it was twenty-five years ago. . . .

Today I would discuss with you the aggressive action which you and I, by virtue of our calling—because we are the servants of peace—must take to build up national strength. The needs to be met are enormous in scope, yet simple in analysis. National strength can be built up only by the adequate application of all the sciences to the provision of armament, munitions and supplies, food, and manpower. Our job is manpower.

Our defense plans, for the immediate emergency, are still young. There is much in the way of organization and coordination yet to come. But as a first step in meeting the vital needs of manpower preparedness, I propose that a coordinator of medical and health preparedness for national defense be appointed under the National Defense Council. There is much for him to do. He would work with and through the Surgeons-General of the United States Army, the United States Navy, and the United States Public Health Service, other Federal agencies, and the national voluntary organizations concerned with the prevention, diagnosis, and treatment of disease.

A first task is the need for listing and classifying professional and technical personnel in the country; for planning and aiding, if and when necessary, the recruitment and mobilization of medical and health personnel.

Another urgent task involves the protection and promotion of the health of industrial workers. . . .

Certain diseases have particular military importance. The venereal diseases are at the top of the list. They caused more disability in the last war than anything except wounds and influenza. Fortunately we have been forehanded in building some machinery in every state to deal with this problem. We need to intensify these efforts, especially in those areas of military and industrial mobilization.

The importance of tuberculosis is accentuated by the current situation. . . .

Of the many military medical and health problems in the tropical Americas, the most important is malaria. . . .

Another strategic medical material, for which we are dependent upon foreign sources, is opium. For four years I have prescribed the total annual amounts which could be imported into the United States. Before and after Munich, I aided our commercial importers to build up a war chest

of opium and morphin. In the vaults at Washington, formerly used to store gold, we have stored enough morphin for at least three years. Our regular source has been from the eastern Mediterranean, now closed. Before this supply is exhausted, we can if necessary grow in certain areas of the United States the pain-relieving poppy plant. But it must be planned now.

Other diseases require our attention. Next to the venereal diseases, mumps is the most disabling of the acute infections among recruits. Meningitis was a great hazard during the last war. Influenza still is a major threat. . . .

When armies are mobilized certain proved immunizations are used. Typhoid fever, yes. Smallpox, yes—since Jenner's discovery of more than one hundred years ago. A recently developed toxoid against tetanus is of proved value and will be used routinely. Effective immunization against gas gangrene would be another great aid. By a few months of coordinated effort on the part of commercial, university, and governmental groups, a practical protection against this major war hazard should be perfected. Here is another job for the coordinator.

Our first concern may be in tropical America. I have discussed malaria. What about yellow fever? Prevalent throughout large areas of South America, a constant threat to the southern half of the United States, we do not have in this country enough of the effective vaccine against it to immunize one regiment! In spite of the requests from year to year, I have not been able to secure funds with which to produce a reserve supply.

These examples, among many I could cite, illustrate my major thesis. There are many diseases, of great military importance, which we could control if we were given the will, the authority, and the money to do it.

If or when war comes, every 1,000,000 men mobilized need 7,500 doctors drawn from civil practice. Dentists, nurses, sanitary engineers are need, too. In the mobilization of four million during the last war, more than a fourth of the effective medical men of the country were called to the colors. Whole counties were depleted of doctors. Many medical schools were almost put out of business, because the best men left for military duty. We should not repeat these mistakes. Today we should investigate who should go, who should stay to practice, to teach, to operate an essential civilian service. We have no machinery now to do this. A coordinator of medical and health preparedness should create the machinery, working with the public health agencies, the schools, and the medical profession itself.

We have a shortage of laboratory technicians. Intensive courses would provide more. Universal training would deplete the ranks of medical students; yet we need doctors each year to replace obsolescence. . . .

Further, let us consider the whole problem of national fitness. The President has recommended that all youth give one year to public service—be trained during this time in some skill. How fit are they from a physical and mental viewpoint? Enrollment should include a careful examination. All correctable defects should receive prompt attention. As yet, there is no organization, no planning of an organization to do it. This is a task projected.

Let us consider two tasks immediately before us. The National Youth Administration employs 300,000 young people. Here is a measurable group, beneficiaries of the Government. After five years no plan has been worked out to appraise their physical status. Should not we take this group of underprivileged youth and apply our proved medical science to relieve their correctable defects?

Employed by the Work Projects Administration are nearly two million people. The nation wants to use their services; they themselves want to serve in the ways they

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

* By Thomas Parran, Surgeon-General, United States Public Health Service.

Read before the New York State Conference of Health Officers and Public Health Nurses, Saratoga Springs, June 25, 1940.

For other comment on medical preparedness, see pages 53, 86, 87 and 100.

can best contribute to national safety. What is their physical status? No one knows. I propose that each of them be examined; that we use methods comparable to those of the Draft Boards of twenty-two years ago, and classify the Work Projects Administration employees physically into three or four classes. . . .

Not through any pity for their working people, but because their scientists proved to them that it was an essential to national power, the Germans began several years ago to provide for the working masses a diet better than ours have now. We have made a beginning in this direction through the food-stamp plan. What we need is an intensive national drive, with rigid scientific controls, to use the food we have to improve the fitness of our manpower.

Though I would not presume to draw up a blueprint for the whole effort of health preparedness, each of the problems mentioned needs prompt attention. With authority from the National Defense Council, several committees of experts, both official and professional, should undertake special responsibilities. What seems now a huge, illimitable job is, in reality, a composite of measurable tasks. . . .

In the past there has been division of opinion and occasional dissension among our professions concerning methods proposed to bring better health and a higher standard of medical care to our people. In the face of danger it is the democratic way—even the herd instinct—to unite for the agreed objectives of safety. We cannot now afford controversies. The preparedness of our manpower for national safety is not controversial. Given a hand in the planning, all of us together, official and professional, can work out methods in which we all believe. . . .

In the dictatorships, the state is served by sacrifice of the individual and enslavement of the men of science. If our democracy is to stand, we—as doctors, as health officers, as health workers, as citizens—of our own free will, because we know it is necessary, must put medical science to work now, fully, to make our men as good as our machines.

* * *

Exhibit at Golden Gate International Exposition: "The Human Eye"

Most physicians are well aware of the political, economic, and social pressure that is being directed against the best interests of medicine and the public health at the present time. This pressure has led certain groups and individuals

* Article contributed by George N. Hosford, M. D. For editorial comment, see page 55.

within the profession to pay, perhaps too late, some attention to a subject, the importance of which was long ago recognized by progressive commercial organizations, viz., the subject of public relations.

Businessmen know that they can obtain from the public a favorable hearing of their viewpoints once they have gained public attention and interest through some entertainment medium. The medical profession, probably wisely, is beginning to utilize the same approach through radio, popular magazines, and other media.

In 1939 an attempt was made to include an ophthalmological exhibit in both the San Francisco and New York Fairs, but both projects were given up. This year, on April 24, Mr. G. L. Bowe, Director of the Exhibits Division of the Golden Gate International Exposition, appeared at a meeting of the Eye, Ear, Nose and Throat Section of the San Francisco County Medical Society to ask if it would be possible to design and assemble an exhibit on ophthalmology for the Science Building on Treasure Island. The response of the members present was so encouraging that Dr. Matthew N. Hosmer, chairman of the section, appointed a committee to consider the proposal, and, if it were found practicable, to arrange the exhibit. The committee consisted of Doctors George N. Hosford (chairman), Joseph Crawford, David Harrington, Robert Irvine, and Dohrmann Pischel.

Within two weeks, sufficient funds had been pledged by individual ophthalmologists and societies and by the California Association of Dispensing Opticians and the manufacturers of ophthalmic supplies so that an exhibit was assured.

The exhibit was completed in time for the record-breaking Exposition attendance of July 4. On this day nearly 12,000 persons tested their vision and inspected the educational features of the exhibit.

Treasure Island's visitors are lining up to work the machine that shows them "what the physician sees inside your eye with an ophthalmoscope." They await their turns to see if they are color blind. They show great interest in learning their visual acuity ratings. They are finding out that the eye is a medical problem and that there is a difference in the diagnostic abilities of ophthalmologists and a group of laymen who, under the name of optometrists, have invaded the field that belongs to the ophthalmologist. They are learning that proper treatment brings with it worth-while results and should not be feared or avoided. Best of all, some of these spectators are going



A view of the exhibit, The Human Eye, at the Golden Gate International Exposition.

away with the feeling that a group of physicians is trying to do something to explain what scientific medicine is.

While the exhibit was planned for laymen, much of the material is very good; the explanations are, as far as possible, pictorial, and we hope the exhibit will be interesting also to doctors who do not specialize in diseases of the eye. The Committee would appreciate having the exhibit called to the attention of patients when there is an opportunity.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Eighth Councilor District Postgraduate Conference: At Tahoe Tavern, August 24-25, 1940

On Saturday and Sunday, August 24-25, at Tahoe Tavern, a two-day Postgraduate Conference will be held. The Eighth Councilor District is composed of the following county societies: Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba.

A preliminary notice has been sent to the physicians of the District by the local Committee on Arrangements: Councilor Frank A. MacDonald, ex-President Robert A. Peers, and Doctor George Briggs.

The Conference will open on Saturday, August 24, with informal luncheon at 12 o'clock noon.

During the afternoon, several papers will be presented. In the evening, at seven o'clock, there will be a dinner, with Doctor Peers presiding; this to be followed by dancing. Keep in mind that the ladies are invited and expected. An Auxiliary meeting will also be held. On Sunday morning, several papers will be given, to be followed by luncheon.

Guest speakers will give the talks and discussions on scientific topics, and officers of the State Association may make brief addresses on organization problems.

The C. M. A. Committee on Postgraduate Activities joins with the local committee in expressing the hope that physicians of the District will find it possible to be present at the Clinical Conference on August 24 and 25.

* * *

Stanford University School of Medicine: Postgraduate Medical Courses for Practicing Physicians

The Stanford University School of Medicine, in coöperation with the San Francisco Department of Public Health and the San Francisco Hospital, in the period September 9 to 13, 1940, inclusive, offers a series of courses for practicing physicians. Each physician may take one morning and one afternoon course, or a full-day course, and all physicians should attend the evening general meetings.

There will be a registration fee of \$25. An additional fee of \$10 will be made to cover the cost of materials used in Course 3, Surgical Anatomy and Operative Technique, and in Course 8, Otorhinolaryngology. Registration closes on August 31.

All fees are payable to Stanford University School of Medicine. Checks and applications for registration in these courses should be mailed to the Dean, Stanford University School of Medicine, 2398 Sacramento Street, San Francisco, not later than August 31.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Titles of courses follow:

I. MORNING COURSES

Monday, Tuesday, Wednesday, Thursday, and Friday,
8:30 to 12:00

Course 1—Pediatrics.

Course 2—Gastro-enterology.

Course 3—Surgical Anatomy and Operative Technique (limited to twenty-four physicians).

II. AFTERNOON COURSES

Monday, Tuesday, Wednesday, Thursday, and Friday
1:30 to 5:00

Course 4—Management of Hypertension and Nephritis.

Course 5—X-ray Diagnosis and Therapy (for doctors experienced in and practicing radiology, but not limited to those who are specializing exclusively in radiology—limited to twenty physicians).

Course 6—Proctology.

III. FULL DAY COURSES

Monday, Tuesday, Wednesday, Thursday, and Friday
Mornings, 9 to 12; Afternoons, 2 to 5

Course 7—Surgical Emergencies, Traumatic Injuries and Fractures (at San Francisco Hospital).

Course 8—Otorhinolaryngology (for specialists only; general practitioners not eligible for this course).

Course 9—Anesthesiology (limited to six physicians. Only those whose practice includes anesthesiology will be eligible to this course).

* * *

Postgraduate Refresher Courses in Pediatrics and Obstetrics

Sponsored by the California State Department of Public Health (Social Security Act), approved by the Committee on Postgraduate Activities of the California Medical Association, and under the auspices of the University of California Medical School, a series of postgraduate refresher courses have been planned for the year 1940 and 1941. A series of three courses have been, or will be given during the summer months of 1940 as follows:

July 8 to 20—*Pediatrics.*

July 22 to 27—*Obstetrics.*

July 29 to August 10—*Pediatrics.*

Additional Courses.—Two courses are planned for the Christmas recess, beginning December 16, 1940. These courses are especially designed for health officers, but will be open to others who may be interested in attending.

A series similar to those recently given is planned for May and June of 1941.

An opportunity will be given to those physicians in the State who may be interested to apply for admission to the two forthcoming series of courses. Attendance at the courses is limited to fifteen physicians for each conference. The privilege of enrolling for both the pediatric and obstetric sessions will be granted as far as the limited number of registrants allows. Physicians who are interested in attending any of these conferences should, for the present, correspond with the State Department of Public Health, 306 State Building, 300 McAllister Street, San Francisco. At a later date enrollments may be transferred to the University of California Pediatrics Department.

An informative statement follows:

✓ ✓ ✓

(COPY)

STATE OF CALIFORNIA: DEPARTMENT OF PUBLIC
HEALTH, BUREAU OF CHILD HYGIENE

The State Department of Public Health announces a repetition of the postgraduate course in pediatrics for phy-

sicians coöperating with the Bureau of Child Hygiene.

Specific Information:

Opening Date—July 8, 1940.

Length of Course—Two weeks.

Place—School of Medicine, University of California, San Francisco.

In Charge—Dr. Amos Christie, Associate Professor in Pediatrics, Acting Head, Department of Pediatrics.

The Faculty—Members of the staff of the Department of Pediatrics.

Registration—Limited to ten physicians. The State Department of Public Health will pay the registration fee for the course and round-trip transportation of each registrant.

This practical course in preventive and clinical pediatrics is part of a series of postgraduate courses to be given at the School of Medicine, University of California, under the sponsorship of six western State Departments of Public Health.

Immediately following the course in pediatrics, a postgraduate course in obstetrics will be given. Following the latter, the course in pediatrics will be repeated for those who have been unable to attend the first two courses in pediatrics sponsored by the State Department of Public Health.

Please use blank below to register with the State Department of Public Health, Bureau of Child Hygiene, 300 McAllister Street, San Francisco.

✓ ✓ ✓

I hereby apply to be enrolled for the postgraduate course in Pediatrics at the School of Medicine, University of California, beginning July 8, 1940.

Signed

Address

Town

Date

306 State Building, San Francisco.

CALIFORNIA PHYSICIANS' SERVICE†

As of July 1, 1,300 additional California State Employees' Association members were added to California Physicians' Service ever-increasing number of beneficiary members, bringing the present total to approximately 16,000.

There is now a representative of California Physicians' Service and Associated Hospital Service located in Fresno, Mr. H. B. Rector. He will cover Fresno, Kings, Tulare, and Kern counties, and it is the firm conviction of all those connected with both California Physicians' Service and the hospital association that there is a great deal of interest in the San Joaquin Valley and that new members will be rapidly acquired in that area.

The study referred to in last month's article is still in progress, and it is hoped that within sixty days it will be possible to present to the profession some interesting statistics relating to the nature and extent of care being rendered to persons belonging to California Physicians' Service; statistics which will, without doubt, contribute

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. Alson Kilgore, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

materially to the intelligent administration of the Service in such a way as to increase the unit value.

✓ ✓ ✓

Looking toward the simplification of paper work for doctors and their secretaries, a new form has been devised which eliminates the use of the small pink referral and initial report heretofore used for every patient who is a California Physicians' Service member. In lieu of this form, provision is made for a report on those cases involving more than three visits, hospitalization, or for cases requiring complete medical study or x-rays or laboratory examinations (beyond urinalysis or, for premarital examinations, a Wassermann). The new form has been in use in San Francisco since late in June, on an experimental basis, and since early in July in Alameda County. Indications thus far are that the form has been well received by doctors, and from the standpoint of the central office it is a great improvement. It is anticipated that within sixty days it will be possible to spread the use of the form to all other counties of the state.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (20)

Fresno County (1)

Darrell Overpeck, *Fresno*

Merced County (1)

Harry R. Maytum, *Merced*

San Bernardino County (5)

Truman T. Ackerson, *Upland*

Leland C. Jacobson, *San Bernardino*

Frank C. Melone, *Redlands*

Henry Wiedow, *Twenty-nine Palms*

Rudolph P. Wiperman, *Patton*

San Diego County (1)

Ralph M. King, *San Diego*

San Francisco County (4)

Joseph H. Davis, *San Francisco*

Jay Jacobs, *San Francisco*

Ambrose P. Merrill, *San Francisco*

Alexander Petrilli, *San Francisco*

Santa Clara County (1)

Harvey S. Pinto, *Agnew*

Sonoma County (4)

Julius Lewis, *Santa Rosa*

Robert Lewis, *Santa Rosa*

Vincent Meyers, *Santa Rosa*

John Siemens, *Santa Rosa*

Ventura County (2)

F. William Cutts, *Camarillo*

Seymour Dudley, *Santa Paula*

Yolo County (1)

Webb D. Garcelon, *Esparto*

Transfers (1)

Homer R. Evans, from Kern County to San Bernardino County.

†For roster of officers of component county medical societies, see page 4 in front advertising section.

In Memoriam

Bond, Elmer C. Died at Hanford, July 8, 1940, age 66. Graduate of the California Eclectic Medical College, Los Angeles, 1899, and licensed in California the same year. Doctor Bond was a member of the Kings County Medical Society, the California Medical Association, and the American Medical Association.

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Bryant, De Witt Clinton. Died at Los Angeles, July 1, 1940, age 91. Graduate of the University of Wooster Medical Department, Cleveland, 1875. Licensed in California in 1917. Doctor Bryant was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Condit, Joseph Dayton. Died at Pasadena, July 5, 1940, age 63. Graduate of Columbia University College of Physicians and Surgeons, New York, 1901. Licensed in California in 1904. Doctor Condit was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Fitzgerald, William Wesley. Died at Stockton, July 7, 1940, age 72. Graduate of Jefferson Medical College of Philadelphia, 1895, and licensed in California the same year. Doctor Fitzgerald was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

+

Frost, Edmund. Died at Stockton, June 26, 1940, age 59. Graduate of the College of Physicians and Surgeons, San Francisco, 1918, and licensed in California the same year. Doctor Frost was a member of the San Joaquin County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Gottbrath, Norbert Joseph. Died at San Francisco, June 20, 1940, age 61. Graduate of Georgetown University School of Medicine, Washington, D. C., 1912. Licensed in California in 1916. Doctor Gottbrath was a member of the Santa Clara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

+

Speik, Frederick A. Died at South Pasadena, June 30, 1940, age 58. Graduate of Rush Medical College, University of Chicago, 1907. Licensed in California in 1912. Doctor Speik was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Thompson, Harry Douglas. Died at Los Angeles, July 3, 1940, age 48. Graduate of College of Physicians and Surgeons, Los Angeles, 1918, and licensed in California the same year. Doctor Thompson was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN.....Asst. Chairman on Publicity

Inaugural Address of Mrs. V. E. Holcombe, President of the Woman's Auxiliary to the American Medical Association (1940-1941)

It is with a feeling of deep gratitude and indebtedness to my predecessors in office that I contemplate serving the Auxiliary in the capacity of president.

In the five years of service as a member of the National Board my opportunity has been unusual to appraise the value of its leadership. I am conscious at all times of the high attainment and unselfish service rendered by my predecessors.

The natural instincts of physicians' wives are not unlike those of other women of the present age. The essential function of woman is that of a helpmeet. When we, as doctors' wives, have that function expressed in moulding the sentiment of our contacts and communities in line with the program and platform of organized medicine, we experience the fruition of our Auxiliary ideals.

This is the opportune time for our supreme effort in reiterating and establishing on a firm foundation, which will withstand the onslaughts of adverse activity, the tenets and postulates of a great and humanitarian profession which have been evolved and perfected by the free and unhampered efforts of great souls, operating in the atmosphere of freedom since the inception of our national life.

In former years the moulding of public opinion was a slow and tedious process. Today, with our multiple means of communication, rapid and radical changes in thought and expression are the order of the day. Consequently, in order to intercept and circumvent false ideas and false conceptions regarding the practice of medicine, it is expedient for the Auxiliary, if it is to serve in its fullest capacity, to be more than ever on the alert to recognize any propaganda or subversive influence which is inimical to the purposes and traditions of the medical profession. We must be cognizant at all times of the changing impacts upon the consciousness of the present-day individual, which determines human opinion and reaction.

This is the age of unified effort. It is only through concerted action that the objectives for which the individual strives can be attained.

Thus, the Auxiliary may best utilize group activities through discreet methods of propagating the knowledge necessary to mould public opinion and make it conversant with the objectives of organized medicine. The attainment of these objectives is to be consummated indirectly by the process of permeation through the laity and through the medium of an opportune word, or impetus to a thought in the right direction, or the judicious redirection of sentiment which may react unfavorably upon the medical profession.

To come from generalities to specific and practical thoughts, let us reiterate the aims of the National Auxiliary. They are:

1. To interpret the aims of the medical profession to

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 5867 Whitworth Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Von Hagen and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

other organizations interested in the promotion of health education.

2. To assist in the entertainment at the sessions of the American Medical Association.

3. To encourage friendliness among the families of the medical profession.

4. To do work approved by the Advisory Council of the American Medical Association.

In order to carry out these objectives we must have a concrete workable program. We do not propose to institute a spectacular program, but we do propose to develop or work out a program according to the needs that arise, the tenor of which is now, as always, self-instruction in matters pertaining to individual and public health, so that we may become instruments in the transmission of this knowledge to the laity. In each community the Auxiliary, through its Advisory Council, should cooperate with its local medical society on the problems of local interest which might include any of the health problems in a long list.

The Auxiliary will continue its interest in *Hygeia*, and in supporting the radio broadcast by the Health Education Bureau of the American Medical Association, Public Relations, Health Education program and legislation.

I especially urge the National and State officers, before formulating plans for the coming year, to familiarize themselves with the platform of the American Medical Association and become conversant with the procedure during the present session of the House of Delegates, the addresses of the duly elected officers of the American Medical Association, and the reports made by the trustees and the scientific councils to the House of Delegates.

Nineteen hundred forty finds the Woman's Auxiliary to the American Medical Association entering upon the nineteenth year of its career. The history of an organization, if it is to be a record of forward movements and high achievements, depends on three factors: the ideals embodied in the purpose of the organization; the efficient, consecrated efforts of its leaders and members in the promotion of its plans and loyalty to its policies; and the ability to meet the exigencies of the times in its benefactions.

The years of serious endeavors, the straightforward facing of ever-changing conditions, the understanding of the importance of health and the difficulties in the professional field, and now the war, have brought to the members of this organization a conviction that the work of the organization, if it is to go forward, must be done in a spirit of "service to humanity." All selfish ambitions must be set aside; idealism become realism; and each phase of the Auxiliary's activities more closely correlated.

The growth in membership of any organization over a period of years would be of no particular value to the cultural, artistic, and educational development of a nation were it a matter of figures only. But the practical idealism of the high purposes of this organization, the constant effort of its increasing membership and the ability to meet the ever-changing forces with which profession and humanity has had to combat, has placed the Auxiliary in the front ranks of those organizations most helpful in creating a new and most vital recognition and understanding of authentic health information.

Body's Temperature Maintained by Delicate Inner Adjustments.—The human body is able to maintain a delicately adjusted internal temperature in spite of the fact that it operates under a much greater range of external temperature and much more severe conditions than any

man-made machine endures, Dr. George A. Skinner, Berkeley, California, points out in *Hygeia, The Health Magazine*.

The air taken into the respiratory tract, he says, may vary from far below zero to much above 100 F. Such air must also be maintained at a relatively constant content of moisture or the mechanism fails to function properly. It is, therefore, a highly complicated problem to meet the necessary conditions, yet most of them are met right at the air intake of our respiratory system, for a marvelous "air conditioner" is located in the cavities of the head, connected with the nose.

"The air is taken from wherever we happen to be," the author explains, "it is warmed and filtered; then moisture is added, and it passes on through the voice box (larynx) into the largest tube of the system, which we call the wind-pipe or trachea. The main air tube soon divides into two tubes of about equal size, and these go to opposite sides of the body. Then begins a series of divisions and subdivisions until there is a large number of branches, much like the branching of a tree. The ends of the finest tubes expand so that each terminal looks like a tiny bunch of grapes. It is in these small expansions that the most important part of respiration takes place, for here the used gases are extracted from the blood, and fresh oxygen is substituted to keep the fires burning that maintain the vital processes.

"The little hairs that we can see in the nose do much to remove dust and keep other foreign matter from entering the respiratory system, unless we become careless and breathe through the mouth. The air filters on all modern automobiles perform a similar function by removing much of the road dust that tends to increase wear on the cylinders. Lining the nasal cavities is a pink membrane which secretes mucus, which captures much of the dust suspended in the air. But in addition to that the mucus is pierced with millions of tiny hairlike structures called cilia. They are constantly sweeping out foreign materials, and as long as they are active, germs have little chance of making a successful landing. If, however, the body temperature begins to go down, as after prolonged exposure to cold, the motion of the cilia begins to slow down, and if the body temperature falls as much as two degrees, the motion may stop entirely. Hence, there is then an opportunity for the millions of germs that always inhabit our upper air passages to find a camping place and start working.

"Heat may escape from the body in a number of ways. We lose heat with each exhalation and with the body excretions. But the organ of greatest heat loss is the skin. When the body heat gets too great, the blood rushes out to the surface of the body, and the glands excrete water, which carries off a large amount of heat. The amount of water thrown off is in direct proportion to the amount of heat to be eliminated.

"When enough heat has been eliminated so that the body temperature will not go above its normal (98.6 F.) the perspiration stops, the blood vessels again contract to normal size, and the body routine is resumed. If on the other hand heat losses are too rapid, instead of the blood vessels dilating and the skin becoming full of blood, the vessels contract, the skin tightens up and the blood is driven into the deeper parts of the body where it cannot lose heat so rapidly. If cold does not come too rapidly, the body will tolerate a prolonged and severe chilling without damage."

Single Syphilis Test Not Conclusive.—In discussing the discrepancies of syphilis tests, Dr. G. Marshall Crawford and Dr. Leon F. Ray, Portland Oregon, in *The Journal of the American Medical Association*, warn that neither a single positive nor a single negative test should be accepted as final. If a history suggestive of syphilis exists, tests should be done repeatedly until they are consistently positive or negative.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

American Medical Association, Cleveland, Ohio. (Exact date not decided.)

California Medical Association, Hotel Del Monte, Del Monte, California, May 5-8, 1941.

Western Section of the American Urological Association, Empress Hotel, Victoria, B. C., July 29-31, 1940.
Dudley P. Fagerstrom, M.D., Secretary, 710 Medico-Dental Building, San Jose, California.

Medical Broadcasts.*

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KTMS	Santa Barbara
KFSD	San Diego	KEX	Portland
KGO	San Francisco	KJR	Seattle
	KGa	Spokane	

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Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of August is as follows:

Saturday, August 3—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, August 7—KECA, 11:15 a. m., The Road of Health.

Saturday, August 10—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, August 14—KECA, 11:15 a. m., The Road of Health.

Saturday, August 17—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, August 21—KECA, 11:15 a. m., The Road of Health.

Saturday, August 24—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, August 28—KECA, 11:15 a. m., The Road of Health.

Saturday, August 31—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

†In the front advertising section of *The Journal of the American Medical Association*, a different roster of national officers and organizations appears each week, each list being printed in revised form about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Incidence of Syphilis.—Among the 20,000,000 men of draft age in the United States, 324,000 today are infected with syphilis, Assistant Surgeon-General R. A. Vonderlehr of the United States Public Health Service recently told the Junior Chamber of Commerce in Washington.

Syphilis is responsible for more nonproductive man days in persons twenty to thirty-nine years of age than the time lost through casualties during the entire period of the last World War. . . .

Dean Schmidt to Aid in Revision of Pharmacopoeia. Dean Carl L. A. Schmidt of the University of California College of Pharmacy will serve as a member of the United States Pharmacopoeia Revision Committee. Dean Schmidt was elected to membership on the committee at the United States Pharmacopoeia Convention held recently in Washington, D. C.

The committee is composed of representatives of the medical and pharmaceutical professions and is charged with the duty of revising the forthcoming twelfth edition of the United States Pharmacopoeia.

Explosive Properties of Cyclopropane.—Results of a study of the explosive properties of cyclopropane, used in anesthetic mixtures, are given in a report just issued by the Bureau of Mines, United States Department of the Interior. The report also discusses the prevention of explosions by dilution of the explosive mixtures with inert gases.

This is the first of a series of reports giving the results of experiments relative to the explosibility of anesthetic mixtures made by the Bureau of Mines in coöperation with a committee working under the direction of the Department of Industrial Hygiene, School of Medicine, University of Pittsburgh, and composed of representatives of the University of Pittsburgh, the American Society of Heating and Ventilating Engineers, and various hospitals and industries in the Pittsburgh district.

Due to a number of distressing accidents in recent years caused by the ignition of explosive mixtures of combustible gases and vapors used in anesthesia, a thorough investigation is clearly of vital importance. . . .

The Bureau of Mines has found that one of the most satisfactory means of eliminating explosion hazards from combustible gaseous mixtures lies in the control of the oxygen content of the mixture. When the oxygen content of explosive mixtures is reduced by the addition of inert gases, the range of explosibility is narrowed and with continued dilution a concentration of oxygen is reached at which the mixtures are no longer explosive or inflammable. Thus by properly controlling the oxygen concentration, gaseous combustible mixtures may be handled and used safely. . . .

Copies of this paper, Report of Investigations 3511, "Explosive Properties of Cyclopropane: Prevention of Explosions by Dilution with Inert Gases," by G. W. Jones, R. E. Kennedy, and G. J. Thomas, may be obtained from the Bureau of Mines, Washington, D. C.

American Board of Ophthalmology.—There will be only one written examination during 1941. This will be held in various cities throughout the country on March 8.

A special oral and clinical examination will be held on the Pacific Coast during 1941, provided there will be enough candidates to warrant it. Applications for this examination should be filed before September 1, 1940, so that the Board may complete necessary arrangements.

Physicians who plan to take the examination during 1941 should write at once to the Board office for formal application blanks, indicating preference of examination place. Address: American Board of Ophthalmology, 6830 Waterman Avenue, St. Louis, Missouri.

Annual Meeting of Eye and Ear Specialists.—The American Academy of Ophthalmology and Otolaryngology will hold its forty-fifth annual convention in Cleveland, October 6 to 11, with headquarters at the Hotel Cleveland.

The Academy, an organization of more than 2,500 specialists in diseases of the eye, ear, nose and throat, carries on an active program of education for its members. In addition to scientific papers, an elaborate series of courses is presented at each convention to bring the members up to date in their chosen fields. More than one hundred of these teaching lectures will be offered this year.

In the past year arrangements have been made to extend the teaching activities to young physicians just entering on specialization. Home study courses are being prepared for any of these young men who wish to take them, and their work will be supervised by members of the academy interested in improving the caliber of specialists in practice.

For information, write to the American Academy of Ophthalmology and Otolaryngology, 1500 Medical Arts Building, Omaha, Nebraska.

The Cleveland meeting will be noteworthy in several respects.

Stutterers Cured by Los Angeles Psychologist.—A complete cure for all stutterers and speech blockers who took a full course of treatment in an experiment on the Los Angeles campus of the University of California was reported by Dr. Harry M. Case of the psychology department.

Doctor Case said that, of thirty cases in the experiment, ten had completed the course of treatment and been discharged as completely cured in an average of eight months. Doctor Case has just taken his Doctor of Philosophy degree.

"An important factor in the recovery of those finally discharged as cured," said Doctor Case, "is possibly found in their exceptionally regular attendance and in their desire to find a solution to their problem. The attendance of patients reporting improvement but no cures was poor."

In treating the stutterers used in the experiment, negative practice was used in conjunction with, or after, the removal of social and vocational maladjustments which caused the speech defect.

Negative practice is the training of the patient to perform voluntarily an involuntary habit. Thus when the stutterer learns to stutter voluntarily he is able to imitate himself perfectly or to avoid the habit at will.

The psychologist said, however, that unless adjustment of socially maladjusted patients is undertaken, in addition to negative practice, the stutterer will not be completely cured.

Speech blockers, patients showing inability to speak under formal social conditions, became worse when treated in the same way as stutterers. A successful treatment was discovered by having the patient engage in a series of conversations, gradually increasing the size of the group until he reached the point where he originally encountered the speech blocking tendency.

Radio Manganese Reveals New Metabolic Facts.—Manganese, the substance which prevents steel from becoming brittle and has other important industrial uses, has developed a new interest in human and animal metabolism as a result of experiments carried on by the Division of Biochemistry of the University of California. Using radioactive or "tagged" manganese from the University's cyclotron or atom smasher, the University experimenters, Dr. David M. Greenberg, associate professor, and W. Wesley Campbell, research fellow in biochemistry, found that the rat excretes all but a trace of administered manganese. Manganese is not well excreted by the kidneys and such quantities as are absorbed by the animal body are taken up by the liver, bones, and muscles. The amount in bone may be of a significance in bone structure since, in the chicken, lack of manganese predisposes to the bone disease known as perosis or, more commonly, slipped tendon. Other tissues may take up varying amounts of the manganese due to storage or to the process of excretion.

It had been previously demonstrated that manganese is essential for the health and well-being of the animal organism. However, little was known about its specific biological functions. It had been found that it aids lactation in the rat and is markedly effective in preventing perosis. The results achieved by the University experimenters demonstrate that radioactive manganese may be usefully employed in the elucidation of many problems connected with its metabolism.

Ivy Poisoning.—Protection against ivy poisoning is possible by use of an alkaline vanishing cream containing sodium perborate or potassium periodate, according to a report by the United States Public Health Service.

This protective ointment for the prevention of ivy poisoning consists of 10 per cent sodium perborate in a vanishing cream which is to be rubbed into the skin of the arms and face of workers before exposure to poison ivy. The vanishing cream fills the pores and forms a protective covering and prevents much of the poison from penetrating the skin.

As the perspiration comes in contact with the vanishing cream in the pores of the skin, a soap is formed and the alkalinity of the soap tends to neutralize the poison ivy, in addition to washing it off and out of the skin. This ointment was developed in the Office of Dermatoses Investigations at the National Institute of Health, Bethesda, Maryland, and reported in the current issue of *Public Health Reports*, weekly publication of the United States Public Health Service (*Public Health Reports*, Vol. 55, No. 27).

This vanishing cream should be freshly prepared at least once in two weeks to avoid deterioration, according to Medical Director Louis Schwartz and Acting Assistant Surgeon Leon H. Warren of the Office of Dermatoses Investigations, and Frederick H. Goldman, Associate Chemist, of the Public Health Service. The cream used in the experiments was slightly discolored, but still active after one month.

In the case of persons working where they might come in contact with poison ivy, the protective cream should be applied in the morning and allowed to remain on until the noon hour, when it should be removed by washing with soap and water; this will emulsify the vanishing cream in the pores of the skin and wash away whatever poison may be in the pores or on the skin.

The cream should be reapplied again after the lunch hour and again washed off in the evening when work is over.

These findings are based on results with a limited number of voluntary workers. Extensive field trials are in progress and will be reported later.

Infant Death Rate in the United States.—The lowest infant death rate in the nation's history was recorded in 1939, according to preliminary tabulations made public by the Census Bureau, Department of Commerce.

The 1939 infant death rate of 48.0 deaths per one thousand live births is based on 108,532 deaths of infants under one year of age. In 1938 there were 116,702 deaths which resulted in a rate of 51.0. The 1937 rate was 54.4 based on a total of 119,931 deaths. The record-breaking mark of 1939 represents the culmination of two decades of general decrease in infant mortality.

Decreases in the infant mortality rate in 1939, compared with the previous year, were reported by forty-two states and the District of Columbia. The rate for California in 1938 was 43.7; in 1939, was 42.2.

Syphilis and What to Do About It.—Under the title "Syphilis and What to Do About It," Dr. C. A. Walker, Chief Surgeon of the Southern Pacific Company, is distributing to employees an interesting twelve-page brochure concerning the disease. The foreword states:

Together with other leading industrial companies, the Southern Pacific is cooperating with public health authorities in the nation-wide effort now being made to stamp out syphilis. As a part of that effort this booklet is issued by the Hospital Department for the information of Southern Pacific employees.

Other excerpts are:

It is the purpose of our Hospital Department to cooperate in the campaign to stamp out this insidious disease, and in order to accomplish this it is ready to do all that it can to diagnose, classify, and give advice as to treatment to all employees. Every attempt is made to accomplish these results without interfering with the patient's employment and to provide treatment at a moderate cost which is within the financial ability of the patient.

The closing paragraph of the brochure states:

It is taken for granted that the diagnosis and treatment of syphilis among employees will be a matter of confidence between physician and patient.

Prepayment Hospitalization Service in Alameda County.—During the past six years some sixty cities and communities throughout the United States have developed some form of approved nonprofit health insurance covering hospitalization in an effort to anticipate and provide for the uncertainty of, and the financial burden imposed by illness. The scope and nature of the benefits available vary under the different plans, but for a very nominal sum individuals or family groups are entitled to three or four weeks of hospital service in any one year. The success of these efforts is emphasized by the fact that to date more than three and one-half million persons have enrolled under these plans and at the present rate of growth the membership may well exceed six million by the end of 1940.

There are three such approved plans operating in the State of California. One of these is the Alameda County Plan, known officially as the Insurance Association of Approved Hospitals, but whose corporate name will probably be changed to the Hospital Service of California. It has a membership of 30,000. This plan was organized three years ago under the sponsorship and financial backing of the Alameda County Medical Association and the Approved Hospitals of Alameda County. Under efficient management its growth has been steady, and up to April, 1940, there has been paid to hospitals for hospital service the sum of \$346,000. There is being established a surplus reserve, which now totals \$100,000. In addition, one-half of the \$25,000 originally advanced by members of the Alameda County Medical Association and by the Approved Hospitals of Alameda County has been refunded and at a recent meeting of the Board of Trustees of the Association action was taken to refund the balance.—President's Message, *Bulletin of Alameda County Medical Association*.

Pacific Association of Railway Surgeons.—The meeting of the Pacific Association of Railway Surgeons will be held in Reno, Friday and Saturday, September 20 and 21. Headquarters will be at the Riverside Hotel. Sessions will be held on Friday and Saturday mornings in the Nevada State Building. The banquet will be held on Saturday evening. Officers of the Association are: William L. Weber of Los Angeles, president; W. T. Cummins of San Francisco, secretary.

Doctor Brown Appointed Director.—Governor Olson has appointed Dr. Bertram P. Brown of Hollywood to succeed Dr. Walter M. Dickie as Director of the California State Department of Public Health. Doctor Brown is a graduate of the New York University Medical School and has been engaged in the active practice of medicine in Hollywood since 1920. Doctor Dickie served as Director of the State Department of Public Health since 1920, with the exception of the period 1931 to 1935. Doctor Brown assumed the duties of his new office on June 22, 1940.

American Board of Obstetrics and Gynecology.—The annual written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 4, 1941, at 2 p. m. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Accidents from Fireworks.—Abandonment of the custom of shooting fireworks and other explosives on the Fourth of July is advocated as a patriotic duty in a statement issued recently by the National Society for the Prevention of Blindness. . . .

"Reports of serious fireworks accidents received by the American Medical Association from hospitals and clinics last year totaled 5,560. These included 158 major eye injuries, many of which resulted in total blindness.

"Nine states now have laws forbidding the sale or possession of fireworks, except for community displays under the supervision of pyrotechnic experts. Such a law was adopted in New York State this year, but it does not become effective until August 1. Other states which previously adopted fireworks legislation are New Jersey, Delaware, Pennsylvania, West Virginia, Indiana, Michigan, Iowa, and Utah. There is also some regulation of fireworks in Kentucky, Illinois, California and Wisconsin."

American Congress of Physical Therapy.—The nineteenth annual scientific and clinical session of the American Congress of Physical Therapy will be held on September 2 to 6, inclusive, at Hotel Statler, Cleveland, Ohio. This year there will be a departure from the usual arrangements in that the mornings will be devoted to an instructional seminar with the scientific program presented afternoons and evenings. This enables physicians to economize on time by attending both the instruction course and the annual convention during the same week. The entire instruction schedule is elective in character. Registrants may pursue only the individual courses they desire. The complete course consists of twelve lectures from a diversified list of forty-eight. The scientific program itself consists of papers, demonstrations and motion pictures covering every branch of physical therapy. There will be a separate scientific program covering eye, ear, nose and throat subjects. Write for schedule, fees, etc., to the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

Los Angeles Health Building Plans Started.—The designing of a \$300,000 Student Health Service Building for the Los Angeles campus of the University of California will begin immediately, President Robert Gordon Sproul recently announced. Funds were appropriated by the regents from the reserve for buildings and improvements, on the recommendation of President Sproul.

The projected plan will provide a complete health service for the Los Angeles students, exclusive of hospitalization. The regents increased the incidental fee on the Los Angeles campus from \$23 to \$25 for the added service. Together with the \$4 Associated Student Body fee, total assessments will be raised from \$27 to \$29.

In his recommendation to the regents, President Sproul outlined the need for an expanded health service, pointing out that at the present time the limited health service available to a student body of about 8,500 is crowded into cramped quarters and operated by part-time employees.

The president said that on the basis of experience on the Berkeley campus, the health service would require a floor area of approximately 23,500 square feet. The building might be designed in such a manner that a bed-patient department could be added at a later date, should it be decided to include hospitalization.

The health program will combine men's and women's services, now separated, under one roof, increase the regular staff of attendants, expand the scope of services offered, and provide additional instruments and equipment needed to meet these requirements.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Change in Financial Rules of Hospital to Be Discussed
Proposal to Permit Patient to Have Assets of \$1,000 Without Lien Will Be Decided

Final discussion of the recent proposal to permit patients at the Los Angeles County General Hospital and other county institutions to have financial assets up to \$1,000 instead of \$250, without signing liens when services are rendered, will be held at 10 a. m. today in the office of Supervisor Gordon L. McDonough.

The conference today is being held prior to final submission of the proposal to the Board of Supervisors for action.

Those who are expected to be present at the meeting are: Members of the Board of Supervisors; Rex Thompson, county superintendent of charities; Dr. Edwin S. Bennett, superintendent, Los Angeles County General Hospital; Arthur Will, executive director, Olive View Sanatorium; William R. Harriman, superintendent, County Farm; S. K. Cochems, secretary, Los Angeles County Medical Association; Gardiner Bullis and Wendie Stuart, Council of Social Agencies; E. F. Hahn, foreman, and Nelson McCook, chairman, Charities and Health Committee, County Grand Jury; Gerald Kelly, County Counsel's Department; Wayne R. Allen, county manager; Paul Sheedy and William A. Pixley, representatives, Property Owners' Association of California.—*Los Angeles Times*, June 24.

Trade or Profession?

The refusal of the Supreme Court to take over the anti-trust case against the American Medical Association leaves, in effect, a lower court decision that the practice of medicine is a trade rather than a profession and as such is subject to the Sherman Act.

To most thinking people this will appear a disturbing situation. The healing art has commercial aspects, it is true; but this decision seems to ignore the others. Since in the Apex Hosiery case decided last week the court held, in effect, that the activities of labor unions are no concern of the Sherman Act if their primary purpose is not interference with commerce and the interference is merely incidental, this decision does not seem to grant to the American Medical Association even the privileges of a labor union.

For the primary purposes of the American Medical Association in moving against a group health organization in Washington was to preserve the standards of medical practice, and not the revenues of doctors. The decisions are difficult to reconcile.—*Editorial, Los Angeles Times*.

Survey on Medical Aid Available for Emergency Started.

In response to a request from the Surgeons-General of the Army, Navy, and Public Health Service, the American Medical Association has set its machinery in motion to secure information relative to the availability and qualifications of professional personnel for service in the federal preparedness program, it is announced in the *American Medical Association News*.

Irvin Abell, M. D., Louisville, Chairman of the Committee on Medical Preparedness of the Association, made an appeal for service addressed to the profession recently. Doctor Abell stated that the doctor, with a knowledge of the measures essential to the conservation of health, the prevention and cure of disease, is in a position to make a signal contribution to the success of the program.

Members of the Association are being contacted by letter, calling on physicians for the services they are best equipped to render.—*Napa Journal*, July 7.

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Olson Appoints Two to Health Board

Sacramento, July 29 (AP).—Governor Olson today appointed Dr. Amos Christie, Berkeley, and Dr. Charles Smith, Stanford, as members of the State Board of Health to succeed Dr. Howard Morrow and Dr. William R. P. Clark, both of San Francisco, who resigned.

Doctors Morrow and Clark retired from the board in protest against the removal of headquarters from San Francisco to Los Angeles.—*Los Angeles Times*, July 30.

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Physicians Plead in Trust Law Test

Washington, June 14 (UP).—Four medical societies and fifteen Washington physicians pleaded not guilty in United States District Court in the Government's test case charging that their opposition to a group health plan violated the Antitrust Law.

The individuals were indicted in December, 1938, along with the American Medical Association, the District of Columbia Medical Society, the Harris County (Texas), Medical Society, and the Washington (D. C.) Academy of Surgery.—*San Francisco Chronicle*, June 15.

* * *

Spreading a Good Idea

California followed the lead of other commonwealths in developing the idea of group hospitalization for dues-paying workers in business and industry, but it is out in front in the effort to make the program include complete medical and surgical care. It is the logical answer to a genuine human need at a time when Government meddlers in men's everyday affairs are talking Treasury-financed "state medicine" and greater tax exactions from employers and employees for various forms of health and accident insurance under the Social Security setup. It meets the problems, as Government, with its waste, inefficiency and ubiquitous politics, could never meet it.

The beginning was made last fall when the California Physicians' Service, under the leadership of President Wilbur of Stanford University, set out to give groups of employed people of small incomes the kind of medical attention they are not ordinarily able to afford, which is to say the best available. It was a dream come true for Doctor Wilbur, who visioned and crusaded for such a program fifteen years ago. The organization is on a nonprofit basis; the services rendered by its thousands of California physician members are to be had for a small monthly fee. A report just issued sets out that nearly 650 separate employee units are now enlisted in the movement, which shows what the public thinks of the plan.

Public health is a vitally important matter, and the wide extension of medical care and hospitalization under the group service plan is one of the most important contributions to it which this generation has seen.—*Editorial, Los Angeles Times*, July 7.

* * *

Government Medical Control Opposed by Physicians' Chief

New York, June 10.—Opposition to governmental control of medical care such as would be involved in compulsory health insurance was voiced here today at the opening of the ninety-first annual convention of the American Medical Association by Dr. Nathan B. Van Etten, the incoming president.

Doctor Van Etten warned the House of Delegates of the American Medical Association, which represents 115,000 physicians, against losing sight of the "dangers to medical practice through concentrations of federal authority."

Rapid development of voluntary health insurance, taken up by the organized medical profession as a preferable alternative to compulsory health insurance in a number of states, was reported here today to the convention.

Thirteen state medical societies of the American Medical

Association were named as having state-wide plans for low-cost medical care in effect or preparation. These state systems are designed to operate on the basis of budgeted prepayment of the medical expense of sickness.

Monthly cost per individual was indicated as running from \$1.50 to \$2.50.

California, the state in which the principal push for the compulsory system has been made, was the first where voluntary insurance was set up by a state medical society. The other twelve states listed today in the American Medical Association report are Colorado, Connecticut, Massachusetts, Michigan, Missouri, New Jersey, Pennsylvania, Utah, Vermont, Washington, New York, and Oregon. The District of Columbia was also included.

In some of these states the movement is still in its early stages.

The American Medical Association data also brought out that hospital insurance is now offered by 103 group hospital associations covering five million persons in twenty-eight states.

In rejecting compulsory health insurance, the American Medical Association has held that the need for low-cost medical care was far lower than pictured by propaganda for socialized medicine and that better ways of handling it could be found than compulsory insurance covering 90 to 100 per cent of the population.

Seeking to work out new methods, a large number of county medical societies, as well as state organizations, have been promoting experiments.—*Boston Christian Science Monitor*, June 11.

* * *

Compulsory Health Insurance Scored

Portland (Oregon), June 22 (INS).—The nation's 45,000 dentists are unalterably opposed to compulsory health insurance, Dr. Wilfred H. Robinson, Oakland, President-Elect of the American Dental Association, was on record today as advising delegates to the Oregon Dental Association convention.

He said the National Association approved setting up voluntary health insurance systems, however.—*San Francisco Examiner*, June 23.

LETTERS

Concerning Physicians Needed for Service in the United States Army.*

(COPY)

WAR DEPARTMENT
OFFICE OF THE SURGEON-GENERAL
WASHINGTON

July 12, 1940.

To the Editor:—With the likelihood of an augmented Army existing for a prolonged period, the War Department has been able to plan accordingly in considering medical personnel requirements.

In reference to extended active duty for Medical Corps Reserve officers, important changes have been made. Reserve officers may now serve in Hawaii, Panama, and other United States possessions, and may receive yearly extensions of active duty for an indefinite number of years until the international situation clarifies and until the future can be viewed with more certainty.

Inclosed is a statement pertaining to extended active duty for physicians which probably will be of interest to your readers. Any publicity given to the substance contained therein will be appreciated by this office.

Very truly yours,

(Signed): JAMES E. BAYLIS,
Colonel, Medical Corps, Executive Officer.

PHYSICIANS NEEDED FOR ARMY SERVICE

The physician, like every other American, has become actively interested in our national security and stands ready to contribute his services as required for military preparedness.

The immediate problem in this connection is one that concerns the War Department, and primarily the young physician. The War Department must procure sufficient additional personnel from the medical profession to aug-

ment the medical services of the Regular Army as the various increases are made in the strength of the Regular Army, as authorized by Congress to meet the partial emergency. The young physician is especially concerned because it is usually advantageous, and is often more convenient for him to serve with the Army.

Present plans of the War Department are designed to make service attractive and instructive for the young physician. If the physician holds a Medical Corps Reserve commission he can be ordered to active duty if he so requests. If he does not hold a commission, but is under thirty-five years of age and is a comparatively recent graduate of an accredited school, he may secure an appointment in the Medical Corps Reserve for the purpose of obtaining extended active duty for a period of one year or longer. Duty is given at General Hospitals, Station Hospitals, and with Tactical Units, and embraces all fields of general and specialized medicine and surgery. Excellent postgraduate training is obtainable in connection with Aviation Medicine. After serving six months of active duty in the continental United States, a Reserve officer may request duty in Hawaii, Panama, or other United States territories and possessions. The initial period for duty is for one year, and yearly extensions are obtainable thereafter until the international situation becomes more clarified and our domestic military program becomes stabilized.

Many young doctors who have served with the Army on extended active duty have taken the competitive examination for entrance into the Medical Corps of the Regular Army. Extended active duty affords an excellent opportunity for the physician to observe modern military medicine and the facilities that exist for a complete and comprehensive medical practice.

Pay is according to rank, and, including subsistence and quarters allowances for an officer with dependents, amounts to an annual sum of \$3,905 for a Captain and \$3,152 for a First Lieutenant; or, without dependents, to an annual sum of \$3,450 for a Captain and \$2,696 for a First Lieutenant. In addition, reimbursement is made for travel to duty station and return.

Further information may be obtained by writing to the Surgeon-General, United States Army, Washington, D. C.

Concerning American Medical Association Program on Medical Preparedness.

(COPY)

AMERICAN MEDICAL ASSOCIATION

Chicago, August 2, 1940.

Dr. George H. Kress,
San Francisco, California.

Dear Doctor:

I am enclosing copies of three resolutions adopted by the Committee on Medical Preparedness at its meeting held in Chicago on July 19. Copies of these resolutions have been forwarded to various government officials in Washington in accordance with instructions given by the committee.

In transmitting the resolution recommending that the National Defense Commission should provide funds to be expended under the direction of the United States Public Health Service for the *training of physicians whose services may be needed in the field of industrial medicine*, it was definitely pointed out that the recommendation offered in the resolution was intended to apply only to any period of emergency that may develop and not to apply after such emergency had ceased to exist.

The Committee on Medical Preparedness considers the resolution pertaining to the *continuance of medical education and hospital operations* to be of great importance, and it is my understanding that the various agencies of the government that are immediately concerned with the preparedness program have this matter in mind.

The committee also considers the resolution pertaining to the appointment of a *coördinator for medical and public health services* to be of great and most urgent importance.

Copies of these resolutions are being sent to all state chairmen of the Committee on Medical Preparedness, to the secretaries of the constituent state medical associations and to the members of the Committee on Medical Preparedness.

On inquiry I have received information from the office

* For editorial and other comment, see pages 53, 86, 87 and 90.

of the Surgeon General of the United States Army that the *age limit for physicians who may be called for military duty* will be fifty-five years. It is possible that the services of some physicians above the age of fifty-five may be used for special purposes, and it is my understanding that some physicians of an age less than fifty-five, including those in the lower age groups, may be assigned to duties concerned with service to civilian groups.

Very sincerely yours,
OLIN WEST, M. D.

RESOLUTION ADOPTED BY COMMITTEE ON MEDICAL
PREPAREDNESS OF AMERICAN MEDICAL
ASSOCIATION, JULY 19, 1940

WHEREAS, The maintenance of the health of the workers in industry is essential to the defense program of the country; and

WHEREAS, The prevention of unnecessary illness of workers in industry is necessary to insure uninterrupted production of essential materials; and

WHEREAS, There exists a shortage in the number of physicians, chemists, mechanical engineers and other professional groups skilled in industrial hygiene; therefore, be it

Resolved, That the Committee on Medical Preparedness of the American Medical Association recommends to the National Defense Commission that the necessary funds be furnished to the United States Public Health Service to provide the necessary training of physicians, chemists, mechanical engineers and other professional personnel in order to cope with the industrial hygiene problem in the present national emergency.

RESOLUTION ADOPTED BY COMMITTEE ON MEDICAL
PREPAREDNESS OF AMERICAN MEDICAL
ASSOCIATION, JULY 19, 1940

WHEREAS, The maintenance of the health of the nation is fundamental to its welfare; and

WHEREAS, The education and training of medical personnel requires long periods of time and special selection of men and women qualified to undertake such study; and

WHEREAS, It is necessary for such purposes to maintain continuous education of medical students; therefore, be it

Resolved, That the Committee on Medical Preparedness of the American Medical Association requests the National Defense Commission, the military and naval services, the United States Public Health Service and the Congress, in preparing for the conscription of personnel, to provide for the continuation of medical education and for exemption from conscription of all medical students and interns in accredited and approved institutions.

RESOLUTION ADOPTED BY COMMITTEE ON MEDICAL
PREPAREDNESS OF AMERICAN MEDICAL
ASSOCIATION, JULY 19, 1940

WHEREAS, There are many organizations interested in health and medical preparedness; and

WHEREAS, These organizations represent various specialties interested not only in the prevention but the treatment of disease; and

WHEREAS, Many recommendations and plans for medical preparedness will be made by these groups; therefore, be it

Resolved, By the Committee on Medical Preparedness of the American Medical Association that we recommend to the President of the United States and to the National Defense Commission the immediate appointment of a medical coordinator of the activities of all medical service related to the national defense program.

Concerning Acceptance in California of Oregon Laboratory Reports (Premarital Examinations).

(COPY)

OREGON STATE MEDICAL SOCIETY
Medical-Dental Building
Portland, Oregon
June 8, 1940

Dr. George H. Kress, Secretary
California Medical Association, Addressed

Dear Doctor Kress:

At the meeting of our Council on June 1, there was discussion concerning the policy of the California State

Board of Health under which it will only accept laboratory reports of syphilis tests in connection with applications for marriage licenses from the Hygienic Laboratory of the Oregon State Board of Health.

The effect of this policy is to prohibit private laboratories in Oregon from performing these tests for applicants for marriage licenses in California, and this in spite of the fact that these private laboratories have been approved by the Oregon State Board of Health to make these tests for applicants for marriage licenses in Oregon.

Our Council voted to request the Council of the California Medical Association to take up this matter with the California State Board of Health with a view to obtaining a change in this policy to permit the acceptance of laboratory reports in this connection from private laboratories which have received the approval of the Oregon State Board of Health.

We shall greatly appreciate it if you will present this matter to your Council at your earliest convenience.

With kindest personal regards, we are

Very sincerely yours,
OREGON STATE MEDICAL SOCIETY.
By CLYDE C. FOLEY,
Executive Secretary.

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
SACRAMENTO

San Francisco, California,
July 9, 1940.

Mr. Clyde C. Foley, Executive Secretary
Oregon State Medical Association
Medico-Dental Building
Portland, Oregon

Dear Mr. Foley:

Your letter of June 8 to the California Medical Association has been referred to this office by Doctor Kress.

In checking our records we find that during the period from September 19, 1939, when the premarital law became effective, to June 30, 1940, only forty premarital tests were performed in Oregon for persons wishing to marry in California.

It is apparent that no great hardship is imposed upon the Oregon private laboratories because approximately five tests a month must be performed in the State Laboratory due to the California regulation.

The rule requiring that tests performed out of the state be run in state laboratories is in accordance with the regulations of most other states having similar laws. It is no reflection upon the competence of private laboratories in any state, but is necessitated by administrative procedure.

You can understand, I am sure, the confusion that would occur if California should make a single exception in the case of Oregon, and the impossibility of keeping the fifty-eight California County Clerks constantly advised as to the current list of private laboratories approved by the Oregon State Board of Health.

302 State Building.

Very truly yours,
MALCOLM H. MERRILL, M. D.,
Chief, Bureau of Venereal Diseases.

Concerning Pacific Coast Examination in Ophthalmology.

(COPY)

AMERICAN BOARD OF OPHTHALMOLOGY

Important Announcement

There will be only one written examination during 1941. This will be held in various cities throughout the country on March 8.

Candidates enrolled in the Preparatory Group who have been advised that they will be eligible for examination during 1941 should make application *at once* to take this written examination.

Application must be made on the regular blanks provided for the purpose and must be received in the Board office before December 1, 1940.

Oral Examinations, 1941: Cleveland, May or June. October (place to be announced later). (See P. S. below.)

Deadline for Case Reports: February 1.

An examination will also be held on the Pacific Coast during 1941, provided a sufficient number of candidates make application for this special examination. (File applications promptly.)

If you plan on taking your examination during 1941, please write at once to the Board office for formal application blanks, indicating your preference of examination place.

6830 Waterman Avenue,
St. Louis, Missouri.

AMERICAN BOARD OF OPHTHALMOLOGY.

Concerning California Nursing Practice Act.

THE CALIFORNIA STATE NURSES ASSOCIATION, INC.

San Francisco, July 16, 1940.

To the Editor:—The California State Nurses' Association has had requests from various organizations and individuals who were helpful in securing the passing of the Nursing Practice Act for information as to the working out of this legislation.

For this reason a communication of information is being sent by the Association to those interested.

As this legislation was given support and endorsement by a number of county medical societies, as well as by many individual physicians in California, it is felt that this communication of information could best reach them through your valued publication.

You will therefore find a copy enclosed which it is hoped you may be able to print in CALIFORNIA AND WESTERN MEDICINE.

609 Sutter Street.

With all good wishes, I am,

Sincerely yours,

(Signed) : HARRIOTT L. P. FRIEND, R. N.,
Director at Headquarters.

✓ ✓ ✓

Dear Friends:

You will be pleased to know that the Governor appointed a representative Board of Nurse Examiners. . . .

As soon as the bill was signed the Association began, through the district associations, to look up nonregistered nurses and assist them to become registered, in some cases organizing review classes, helping the nurses to obtain necessary forms, and lending books. As the State Association has forty-five district associations, it was possible to reach those nurses needing such help.

The Advisory Council which has been appointed had its first meeting on July 1, 1940. (Dr. Harry H. Wilson of Los Angeles and Dr. Charles A. Dukes of Oakland are the representatives thereon of the California Medical Association.)

It is our expectation that the Advisory Council will study the trends of nursing and advise ways and means of improving nursing in California. From what evidence we can gather, this law has been quite effective in preventing those who are not graduate nurses from practicing as such, now that the law protects the title "graduate nurse."

Persons may still care for the sick for hire without license, but may no longer impersonate a graduate nurse and deceive the patient employing, as well as overcharging for their services.

The law has not prevented qualified nurses from other states from coming into this state. From January 1 to June 21, 1940, the number of licenses to out-of-state nurses was 2,409, compared with a total of 1,781 for the whole year of 1939. There are also 32,153 registered nurses in the state who obtained registration in exchange of certificate between January 1 and June 21, 1940.

We have every reason to believe that the Nursing Practice Act is serving to protect the sick from exploitation in that it is now possible to ascertain whether or not the person employed is qualified by display of license. All possible publicity should be given to the fact that graduate nurses are required to be licensed as registered nurses and that license should be shown on demand of the patient, the physician, patient's friends, etc.

We believe that you may be assured that the Nursing Practice Act is a piece of legislation which is working to improve the public health of the state.

609 Sutter Street, San Francisco.

Cordially yours,

PAULINE W. GAGE, R. N.,
President, California State Nurses Association, Inc.

Concerning California Medical Association Cancer Exhibit at the Golden Gate International Exposition.

(COPY)

GOLDEN GATE INTERNATIONAL EXPOSITION

San Francisco, July 4, 1940.

My dear Doctor Kress:

I was through the Hall of Science today and stopped to look at the Cancer Exhibit.

I have learned that it was through you and others associated with you that this very fine exhibit was made possible for the Exposition. I want to extend to you the sincere appreciation of the Exposition as a whole, as well as my personal thanks, for the interest which your group has taken in presenting a most interesting and unusual exhibit. You and the others should feel highly complimented on such a splendid portrayal of a most difficult subject.

Sincerely,

MARSHALL DILL, *President.*

Concerning an Error in Directory of Board of Medical Examiners of the State of California.

STATE OF CALIFORNIA

DEPARTMENT OF

PROFESSIONAL AND VOCATIONAL STANDARDS

BOARD OF MEDICAL EXAMINERS

San Francisco, California,

July 23, 1940.

Re: James C. Weld, M. D.

To the Editor:—Enclosed herewith please find a copy of a self-explanatory letter addressed to James Cushing Weld, M. D., and will greatly appreciate your publishing said letter in the next issue of CALIFORNIA AND WESTERN MEDICINE.

With kindest personal regards, believe me

Very truly yours,

(Signed) : C. B. PINKHAM, M. D.,
Secretary-Treasurer.

(COPY)

San Francisco, California,
July 23, 1940.

James C. Weld, M. D.
1036 South Alvarado
Los Angeles, California

Dear Doctor:

I trust that you will accept the apology of the Board of Medical Examiners and the undersigned for inadvertently listing your name in the 1939 Annual Report as one whose license was revoked by the Board of Medical Examiners.

While it is true that the Board revoked your license at its July 1939 meeting, it is also true that on November 30, 1939, the Superior Court in and for the county of Los Angeles, in effect, set aside the Board's action and ordered your license restored without prejudice to the Board's right to pursue such other proceedings as might be proper in the premise.

Pursuant to the court's order, the Board at its regular meeting held in Los Angeles, February 26, 1940, annulled as of July 13, 1939, its former action and restored your medical license. You now are and at all times have been in good standing.

You will note by reference to the 1940 directory published by the Board of Medical Examiners that your name is *not* listed on page 10 thereof under the heading of "Penalty Imposed for Violations of . . . the Medical Practice Act." You will further note that your name is listed in the alphabetical section of said directory (page 136), as well as in the Los Angeles County listing on page 231 of said directory. Only licentiates in good standing are so listed. The failure to remove your name from the list of those disciplined by the Board was purely an oversight.

I am today forwarding a copy of this letter to George H. Kress, M. D., Editor of CALIFORNIA AND WESTERN MEDICINE (official journal of the California Medical Association) with the request that he publish same in the next issue of that journal.

I trust the oversight referred to herein has not caused you any embarrassment.

With kindest personal regards, believe me

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Responsibility of One Physician for Malpractice by Another

Although generally a physician may be held liable only for his own acts and may with safety call in another physician to aid him in a particular case without accepting responsibility for negligence of such other physician, there are certain situations in which a physician is responsible for the acts of other persons and these should be constantly kept in mind.

Employees.—With few exceptions, a physician is liable for negligence of his assistant, apprentice, agent or employee. The failure of a nurse to remove a sponge from a patient's abdomen or other situs of an operation, is typical of this source of liability. Where it can be shown that the nurse was an employee or assistant of the operating surgeon, the surgeon may be held liable. However, since there are circumstances in which the hospital, rather than the surgeon, is responsible, reference is made to a more detailed discussion of this question, to be found in the Medical Jurisprudence article in the April, 1937, issue of this publication. The important factor in establishing this type of liability is the control which one is presumed to

exert over persons who stand in an employee relationship to him.

Nurse or Attendant Not an Employee.—Since it is a matter of common knowledge that it is customary in many hospitals for the operating surgeon to leave the post-operation care of patients, in the matter of dressing, packing and unpacking wounds, to the house doctor (intern) and staff nurses, the surgeon is not responsible for the negligence of such persons unless it is shown that the hospital was owned by the doctor or he had some other peculiar control over such assistants.

Physicians Called in to Help: Consultants.—It may be stated that generally one physician may with impunity call in another physician to assist him so long as he uses due care in the selection of that physician. He may select anyone whose professional standing in the locality is good and who is experienced in that particular line of practice. Thus, in a case where it appeared that the patient was under the general treatment of one physician but another physician of good standing was called in to diagnose the disease and prescribe or direct treatment for its cure, in an action for malpractice against both physicians, it was held that the one who was specially employed by the patient should only be liable for such damages as resulted from his connection with the case on the occasion of his visit, and that he was not liable for what the other physician did or omitted to do in his absence.

Substitute.—A physician, due to other calls, is often required to send a substitute to treat a patient. Just as in the case where a second physician is called in to help, the first physician's liability depends upon the care which has been used in the selection of the substitute. If reasonable care has been exerted, there is no liability.

Two or More Physicians Engaged Independently.—The courts have stated the rule applicable to this situation as follows:

Each, in serving with the other, is rightly held answerable for his own conduct, and as well for all the wrongful acts or omissions of the other, . . . which in the exercise of reasonable diligence under the circumstances, he should have observed.

Thus, it may be seen that where there are two physicians on the case, both hired by the patient independent of the other, each has the duty of exercising due care toward the patient and neither can permit the other to do a wrongful act under his own observation. Added to this may be a responsibility for each other where they are acting jointly in a particular endeavor such as an operation or specific act of treatment. In such case, each is held liable for the acts of the other. It has been held, however, that where a physician could have taken no part in an operation other than in administering the anesthetic, he could not be liable for the negligence of the operating surgeon since the two were not acting jointly in the operation.

Where One Physician Contributes to an Injury Caused by Another.—Generally, one may not be excused from one wrongful act merely because another was also involved in a similar wrongful act. Thus, where a physician's treatment of the plaintiff was negligent from the start, the fact that another physician subsequently had exclusive control of the case will not relieve the defendant of his negligence while he was in attendance. Sometimes it is not easy to establish which of one or more surgeons or physicians actually caused an injury. In such case, if the physicians or surgeons were giving joint treatment, each is liable for any injury which may result. Thus, where a family physician recommended a surgeon to perform an operation, at which he was present and assisted, although not personally using the knife, he was held to be jointly liable because both doctors were considered as joint tortfeasors.

†Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 8, August, 1915

From Some Editorial Notes:

California and the American Medical Association.—Probably nearly 50 per cent of the members of our State Society attended the sessions of the American Medical Association held in San Francisco in June. Up to the time of closing the registration on Wednesday night, for publication in the last Bulletin which was issued Thursday, 1,064 of our members had registered. A good many registered on Thursday though the exact count could not be obtained on account of the hurry and pressure of closing things up. That is a mighty good showing, as we think you will admit. . . .

Remember Your Friends.—There was a time, not so many years ago, when no respectable publication would refer to its advertisements or its advertisers. To be sure, many items boosting advertised things appeared in some periodicals—mostly medical (?) journals—but these were what is known as of the “reading notice” variety; carefully prepared by the advertiser and furnished to the publication; they were run as part of the advertising obligation. Now, however, and largely through the influence of your own Journal, all that has changed; we are proud of our advertisers and our advertising. Nothing goes into the advertising pages that is not as carefully scrutinized as the matter that goes into the reading pages. . . . Help your friends and those who help you. Read the advertisements in this issue.

Progress or Retrogression?—The new way of spelling “progress” and “reform” seems to be “politics” and “retrogression.” Cheap politics mixed into medicine makes a pitiful mess, and especially when it comes to public health matters; for the people understand the importance of, to them little things, so not at all! . . .

Healthy Growth in California.—Every three years, according to the by-laws, the House of Delegates of the American Medical Association appoints a committee on reapportionment, which committee goes over the membership returns of the several state associations and determines the number of delegates which each state shall have for the next succeeding three years. This was the year of reapportionment, and the report of the committee made but two changes; California was given one more delegate, so for the next three years we shall have four delegates and not three, as previously. . . .

Good Legislators—And Others.—It has reached the attention of the Journal that some members of the last legislature who stood for better medical legislation have felt somewhat disturbed or annoyed because of our mild criticism of the net result of legislative effort. . . .

There is no good reason why we, as a profession and as an organized profession, should go to the legislature and beg for anything. We do not need protection, but the people do. If it is the wish and the will of certain legislators to remove the protection which just medical laws and high standards for medical licensure give to the people of the

(Continued in Front Advertising Section, Page 5)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

A regular meeting of the Board of Medical Examiners was held in Native Sons Hall, San Francisco, June 24 to 27, 1940.

One hundred ninety-two applicants wrote the examination, including physicians and surgeons, drugless practitioners, and chiropodists. A number of foreign émigré physicians who had completed the required one-year internship and satisfied the requirements of the California law were also included.

Seventeen licensed physicians and surgeons were on the calendar for hearing.

The licenses of Walter Hoyt, M. D., Gridley, and Theodosia Maude Ramer, M. D., San Diego, were revoked, based upon charges of alleged illegal operation.

Edith Mary Stoker was placed on probation for a period of three years, based upon conviction of a crime involving moral turpitude.

After hearing the evidence in the case of Nathan Housman, M. D., the Board voted the evidence was not sufficient to sustain the allegations in the complaint, and pending charges were dismissed.

On June 24, 1940, the Board restored the midwife license of Caterina Reorda (revoked on June 30, 1937) and she was placed on probation for a period of five years.

News

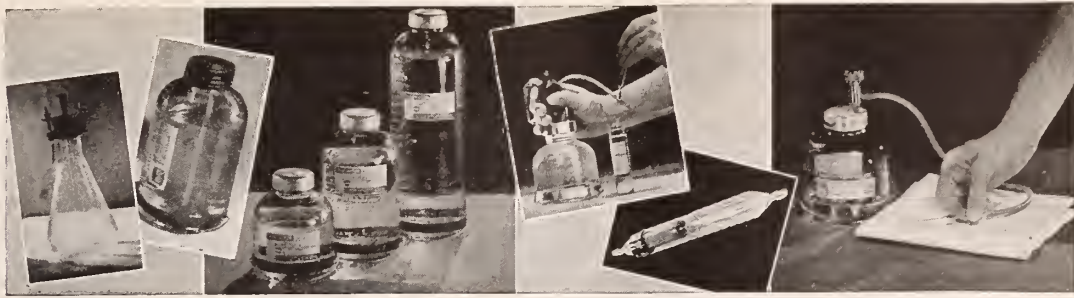
“Mobilization of the nation’s physicians for service in time of war is being carried out swiftly under a program launched by the Surgeons-General of the Army and Navy, it was learned here last night. Every registered physician is getting a questionnaire in which he is asked to report his age, qualifications, and type of work desired in case of national emergency. The questionnaire is being carried [sent] out by the American Medical Association, and is expected, when completed, to furnish the military chiefs with a complete and detailed index of the nation’s available resources in medical personnel. When this phase is completed, the organization program will be carried through to the end that, should war be declared, the entire medical branch of the service could be mobilized and set in operation on a few hours’ notice.” (San Francisco Examiner, June 20, 1940.)

“Two of Stanford’s School of Medicine staff, whose combined length of service to the University is fifty-five years, will retire from active teaching posts in less than two weeks. They are Doctors Edward Sewall and Harvard McNaught. Both men, experts in eye, ear, nose and throat work, have been attached to the school for the medical students in Stanford Hospital in San Francisco. . . .” (Palo Alto Times, June 4, 1940.)

“Dr. Elmer Belt of Los Angeles and Dr. Francis Marion Pottenger of Monrovia were appointed members of the State Board of Health by Governor Olson today. Doctor Belt, attending physician at the Children’s and other hospitals in Los Angeles, succeeds Gustave Wilson of Sacramento, whose term expired last January 15. He will serve

(Continued in Front Advertising Section, Page 11)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



1929

1931

1934

1935

1936

1937

1938

1939

1929: FIRST to supply bulk Parenteral Solutions commercially in vacuum containers. 1931: FIRST to supply solutions in a perfected container with band, bail, permanent metal identification disk, and vacuum index—the exclusive Va-

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On request, editorial bulletins describing . . . BAXTER'S Parenteral Solutions . . . the new Transfuso-Vac technique of blood transfusion.

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Few things are more important to a community than the health of its women. If strong is the frame of the mother, says a proverb, the son will give laws to the people. And in nations where all men give laws, all men need mothers of strong frames.—T. W. Higginson.

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Agitation for State Hospitals Not Confined to United States.—"The United States is not the only country in which there is some agitation for a complete state system of hospital services," *The Journal of the American Medical Association* declares in an editorial on "The Voluntary Hospital."

"As is pointed out by Mr. A. V. J. Hinds, of Great Britain, this is a thought that occurs to any individual who finds himself subjected to the visitation of the collectors for the nonprofit voluntary hospitals. It disturbs also the people who have been contributing to hospitals in the past and now find their taxes so great that they must cut down their contributions. Indeed, governmentally minded persons themselves in their agitation for a discontinuance of voluntary hospitals urge that complete administration by the state would free many people from these personal annoyances. Of course persons who are interested in hospitals from the point of view of professional relationships might feel that the benefits to be derived from freedom of action are worth considerably more than any annoyance that might result from the existence of the voluntary system. It has yet to be established, moreover, that a state system could operate with more efficiency or at a lesser cost.

"Mr. Hinds examines the arguments in behalf of both the voluntary hospitals and a state system. He considers particularly the arguments of those who insist that hospital service should be like the disposal of sewage, the provision of water and education—state-managed services wholly. He comes to the ultimate conclusion that no government would today advocate taking over the voluntary hospitals in Great Britain. They are doing the work efficiently and, as far as the taxpayer is concerned, free of charge. It is on the privately owned hospitals that the community must depend

for a trained medical profession, both specialist and general practitioner. The records show that without a doubt the voluntary hospitals have been the most important of the sources of advancement in medical science.

"The ultimate justification for the continuance of the voluntary hospital system as a permanent feature of medical services lies, the British leaders point out, in the association of the voluntary hospitals in teaching and research, but especially because such association is the best guaranty of an alert and enterprising medical profession. On the existence of a medical profession of high standards depends the efficiency of hospital treatment, the advance of medical science and the maintenance of high standards in every medical function.

"Continuing in this vein of philosophic thought, Mr. A. V. J. Hinds writes:

"It is clear that hitherto the voluntary hospitals have always attracted to themselves the most brilliant medical men. The merit of their organization is that they do in fact create rather than attract the best men. The width of experience available to the Honorary engaged partly in private practice and partly in hospital work has already been emphasized, but there is an important aspect of it that needs elaboration. The Honorary's work for the hospital, as doctor, teacher, and research worker, must be maintained at the high standard which is necessary to provide him an income in his private practice. If the quality of his hospital work deteriorates, his reputation is damaged and his private practice suffers. He thus has a constant incentive to achieve distinction which would be lacking if he were a salaried officer of the hospital, an incentive to give of his best to his hospital work—which is a public service—in order to benefit his private work which is his livelihood. Furthermore, his eminence in his profession is maintained only by the confidence of those he serves, and the persons

(Continued on Next Page)

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(Continued from Preceding Page)

who have the greatest say in giving him employment as a consultant in a private case are the general practitioners, members of his own profession who are judging him as expert."

"The complete analysis of the situation leads our British colleagues to a six-point statement, in which Lord Dawson of Pem joins Mr. Hinds:

"1. The voluntary hospitals ensure that only the best brains of the medical profession are accorded distinction, by subjecting them to the rigorous test of recognition by their practicing colleagues engaged in the same work in the same profession. They do not obtain positions of eminence as a result of selection and promotion decided solely by a political body or a lay administrator.

"2. The voluntary hospitals ensure that the best brains of the medical profession are not only at the command of the wealthy, but are also at the service of the public as practitioners in the hospitals. The benefits of first-rate medical attention are not confined to one class of the community.

"3. The voluntary hospitals ensure that the best brains of the medical profession are not only engaged in the practice of medicine, but are also at the disposal of the public as university teachers of medicine. There is no separation of the practical work from the teaching of it.

"4. The voluntary hospitals ensure that for the performance of these public services the medical profession is remunerated, not by fixed salary, but indirectly by the rewards of private practice, in such a way, therefore, as to provide the maximum incentive for the achievement of excellence. There is no danger that a hospital appointment or a teaching appointment will be regarded as a sinecure.

"5. The voluntary hospitals ensure that the teaching of medicine in the universities, and research into new methods of treatment in the hospitals, are guided and controlled by independent laymen whose loyalty to a single purpose permits and inspires them to provide the funds required for a bold policy of advancement in research. There is not the necessity to confine expenditure along the lines imposed by direct responsibility to the masses of the public.

"6. The voluntary hospitals ensure that in one of the most important spheres of social life there is a variety of approach, on the one hand by public bodies, and on the other

by private and voluntary institutions. The existence side by side of the two types of effort affords a useful basis of contrast, and a stimulus to friendly and healthy rivalry. Experiment of every kind is easier for the private and voluntary agency, but both types benefit from the results of research which proves itself successful.

"The voluntary hospitals in Great Britain have been undergoing many vicissitudes similar to those that threaten ours, perhaps to some extent even greater because of the degree to which the state in Great Britain has already entered into medical service. Today the voluntary hospitals in Great Britain are appealing to the public for their very lives, asking individual citizens to give of their utmost to sustain institutions whose unique gift to public life is bound up with their dependence on the efforts of the individual citizen. Sentiment alone might well be sufficient to urge support because an altruistic people has always recognized that the care of the sick is a fundamental spiritual motive. But here now are conclusive scientific arguments to support the appeal to sentiment with an appeal to reason—one which every free citizen of a free-minded country must heed if he would sustain those institutions which are in themselves a symbol of freedom."

Report Shows Big Variance in World's Bathing Customs.—Among the strange things still differentiating people in this modern world are the baths they take, how many and just how.

A study of bathing customs, made for the American Medical Association's health magazine, *Hygeia*, shows the implements of the bath in various lands include such odd things as sand, snow, birch twigs—and rented water.

The report, by Mildred Brennan of Chicago, indicates that, while many national customs have tended to become more alike, the manner of keeping clean remains vastly different.

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It said one reason for contrasts with the United States is that this country owns 95 per cent of the world's bathtubs.

This situation makes it nice for natives, but vexes the innocents who go abroad.

London Is Short on Tubs.—In London, a survey one summer showed 100,000 American visitors in town—and only 4,000 hotel rooms with baths. In Germany, bathtubs often have corrugated bottoms.

The "C" on faucets in Italy stands for "caldo"—which in Italian means hot. The usual result, therefore, of turning on a faucet is painful, or at least surprising, unless tourists accidentally do as the Romans do.

It was alleged in Paris only 25 per cent of the population has a private bath in the home. The city has one hundred public bathhouses, with about twenty tubs each. From statistics on their use it was estimated unofficially (and without confirmation) that Parisians average one tub bath every four months.

Russians Use Twigs.—A bathtub costs more than a grand piano in Russia. Soap brings \$3.50 a cake—and try to find one. Instead of soap, some Russians beat their bodies with bundles of birch twigs, on the theory it opens the pores.

In Karaganda, Russia (50,000 population), the bathhouse has one scrub brush, and a foreign bather must deposit his passport—to insure return of the brush.

Well known are the Japanese public baths, with tanks which accommodate a dozen or more people. The water is heated to 120 degrees, and women attendants insist on rubbing every bather's back. Only well-to-do families have private bathrooms.

The Finns, while steaming themselves in the famous log bath huts, swish their bodies with birch or cedar branches to produce a pink glow—and afterward frequently rub themselves with snow.

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Snakes Bother in India.—In India, natives use a simple tub, and because of snakes Europeans have learned to be wary of sponges and to look before they leap into a bath.

On Arabian deserts water can be used only for drinking purposes, so the bath consists of a vigorous rub with sand.

Luberitzbucht in southwest Africa is one of the earth's driest places. Consequently, a four-gallon tin of water costs \$1. This is not the purchase price, however, but the "rent." The water is saved and used to water plants.—*Fresno Bee and Republican*, July 14.

Patients subject to febrile reactions following air refills have little or no reaction following nitrogen or helium refills. The febrile reaction probably represents a flare-up of tuberculous pleuritis following the increased oxygen supply of the refill.—H. E. Pugsley, M.D., *American Review of Tuberculosis*, March, 1940.

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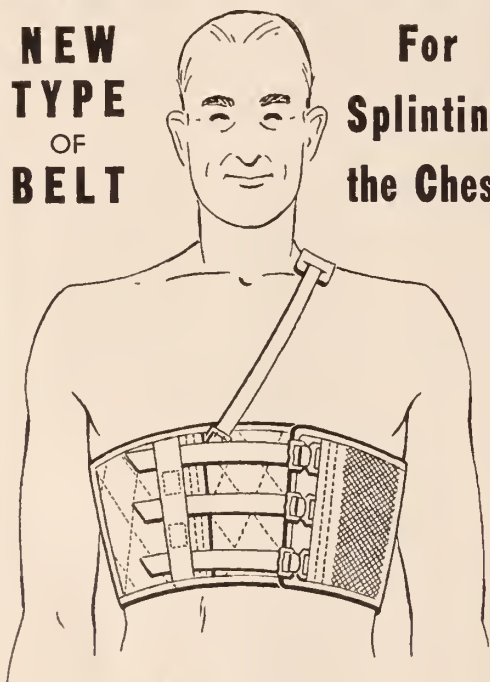
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Kidney Edema Benefited by Acacia.—A treatment method which brought about early recovery in 90 per cent of patients suffering with edema (swelling of body tissues due to retention of fluids therein) as the result of dysfunction of the kidneys is described in *The Journal of the American Medical Association* by Dr. Arnoldus Goudsmit, Jr., Philadelphia, and Dr. Melvin W. Binger, Rochester, Minnesota.

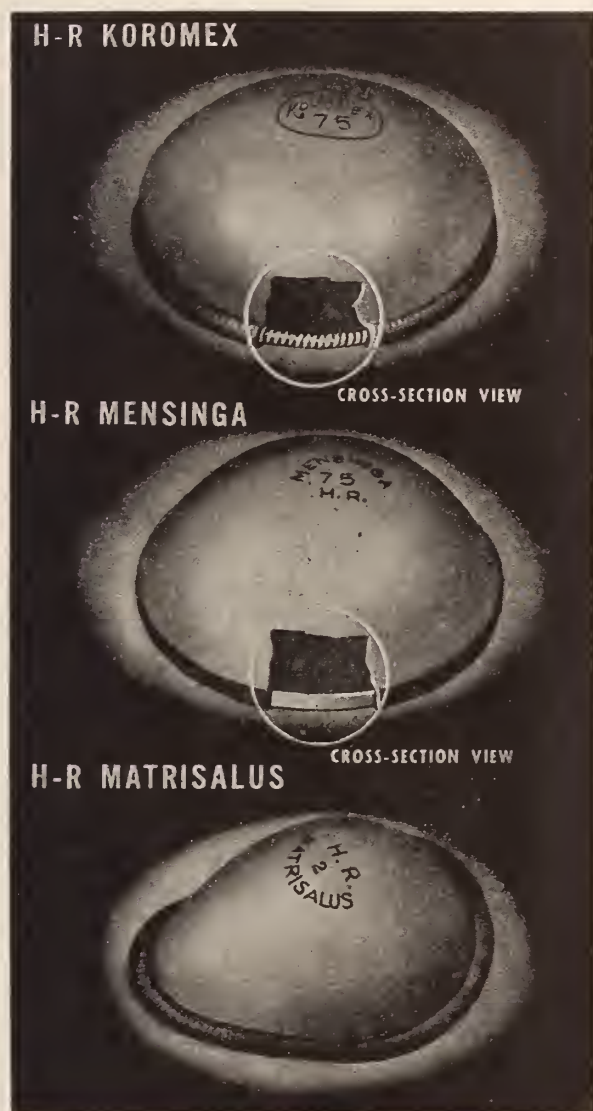
The treatment, which the authors say should be carried out in a hospital because close supervision is necessary, involves rest in bed until recovery is well under way, the use of a salt-free diet with a high protein content, a strict limitation of fluids, the administration by mouth of potassium nitrate in pill form, and injections into a vein of acacia, a dry, gum-like substance, also called gum arabic, obtained from the acacia tree.

"When a patient is thus treated," the two physicians say, "the edema will soon disappear. Rarely are additional measures necessary.

"Not so very long ago it was necessary for such patients to be hospitalized for many months before elimination of excessive fluids was accomplished, if it ever was accomplished at all. Such protracted invalidism is comparatively rare at the present time."

British Embassy Registering American Physicians for Service in Britain.—"The British Embassy is registering the names of American physicians who volunteer for service in the United Kingdom in the treatment of war casualties so as to have available a list of men who may be called on if the need arises," *The Journal of the American Medical Association* reports. "The statement is made that these men are required mainly for the treatment of civilian casualties and that there is no question of enrolling these men in the medical services of the war forces."

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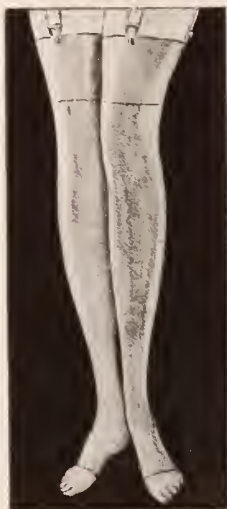
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Osler at Old Blockley.—"Osler at Old Blockley," a painting in oil by Dean Cornwell, was unveiled at the dedication of the Osler Memorial Building on the grounds of the Philadelphia General Hospital this past June and was later exhibited at the American Medical Association convention in New York.

The painting depicts one of Osler's outstanding contributions to medicine, namely, bringing medical students to



the bedside of the patient for clinical study. In the painting Osler is shown at the side of an elderly patient on the hospital grounds. Surrounding Osler and the patient are internes who have stopped with him as they were on their way to the autopsy house to observe one of his famous postmortems. This autopsy house, now the only Osler Memorial Building in the United States, is shown in the background. This memorial was made possible by a grant from John Wyeth & Brother.

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Colored reproductions of "Osler at Old Blockley," 16 by 19 inches in size, suitable for framing, may be obtained free by addressing requests to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco. Physicians' names requesting reproductions will be forwarded to John Wyeth & Brother, 1600 Arch Street, Philadelphia, Pennsylvania. Prints will be sent from Philadelphia.

Army Medical Corps Needs Additional Personnel.

"The office of the Surgeon-General of the United States Army Medical Corps points out there are now authorized for the army of 280,000 an additional 1,283 Medical Reserve officers," *The Journal of the American Medical Association* says. "Of this number only 363 have been procured, leaving 920 still required. Approximately 600 medical officers will be needed for the additional 95,000 men. It is stated that the War Department will authorize active duty for lieutenants to age thirty-five and captains to age forty. The duty will be for one year, to be renewed as required. Physicians who are anxious to obtain some military experience, and particularly young physicians who are seeking at this time an outlet for their services, will find here an opportunity to accept service for one year or for more if they desire it to obtain experience, and an income, and at the same time fulfill a patriotic duty."

Acute rheumatic fever is a serious disease which may have either an abrupt or a gradual and insidious onset.—*Hygeia*.

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Infantile Paralysis Victim Delivered of Healthy Child.—Delivery of an apparently healthy child from a mother whose pregnancy at five and a half months had been complicated by poliomyelitis (infantile paralysis) is reported by Dr. Joseph R. Morrow and Dr. Sanford A. Luria, Ridgewood, New Jersey, in *The Journal of the American Medical Association*.

One week before the woman was admitted to the hospital she had complained of severe headache and of feeling "feverish." This condition was followed by nausea and vomiting. Twenty-four hours later she noticed an inability to move her legs and complained of severe pain through both lower and upper extremities and the lumbosacral region (the loins and sacrum).

Examination at the time she was admitted to the hospital revealed that the neck was markedly rigid and that the right muscles of the palate and the lumbosacral group of muscles were paralyzed. There was weakness and partial paralysis of the arm, forearm, and shoulder girdle of both upper extremities. There was complete flaccid paralysis of both lower extremities from the trunk line down.

The patient's condition was considered critical for eighteen days, following which she began to show gradual and progressive improvement. Within the following four weeks it was noticed that there was some muscle restoration in both upper extremities, the chest, and the trunk.

Although the patient was discharged with the understanding that she should be further hospitalized for orthopedic and obstetric care, she preferred to remain at home under the care of her family physician and obstetrician for economic reasons. The course while at home was also uneventful, except for persistent anemia.

The delivery, which took place last December 20, was rather simple. "Her course after delivery was also uneventful," the authors state. "In spite of an apparently

lowered resistance, no infections developed. She had received three transfusions, and her blood picture returned to normal within three weeks." When examined a short time ago the infant was in good health, showing no evidence of paralytic involvement.

The authors mention previous reports by others of eleven similar cases. The small number of reports, they say, suggests that the incidence of epidemic poliomyelitis during pregnancy is probably rare.

Pupils with Hearing Defects Benefit from Reading Lips of Teachers.—Intelligent attempts of teachers to facilitate lip reading by pupils with defective hearing would be a tremendous advantage to such children in their school work, Louise M. Neuschutz, New York, suggests in *Hygeia, The Health Magazine*.

"For such pupils," she says, "a front seat near the window is almost a prerequisite. The face of the teacher should be in the light so that the hard-of-hearing pupil can watch her lips. To speak as naturally as possible, moreover, avoiding exaggerated lip movements is the best way to help him. Word for word utterance is to be avoided. Eyes and mind cannot take in particles of speech; the lip reader must have a full sentence in view before he will be able to get at the context. Shouting and gesticulating will only serve to upset him, and he won't be able to understand anything. In case a sentence is hard to read from the lips, its phrasing might be changed, thus making it easier to see."

Swelling of Mouth Due to Mango.—Two cases of swelling and inflammation around the mouth, caused by eating mango fruit, are cited by Dr. Samuel J. Zakon, Chicago, in *The Journal of the American Medical Association*.

The condition is attributed to a substance contained in

(Continued on Next Page)

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(Continued from Preceding Page)

the peel of the fruit before ripening which protects it from insects. "This substance," the author explains, "remains so active in some varieties, even after the fruit has ripened, as to affect some people eating the fruit with what is known as 'mango poisoning.'"

"With the increasing use of this fruit in the daily diet, the mango should be seriously considered as a causative factor in acute skin inflammation of the face."

"Runts" Need Attractive Nicknames.—An attractive nickname which can hold its own against such appellations as Shrimp, Shorty, or Half-Pint is an excellent endowment for the undersized child who is classed as a "runt," Marjorie Holmes Mighell, Texarkana, Arkansas, suggests in *Hygeia, The Health Magazine*.

Also recommending other methods of helping such a child to overcome his handicap, Mrs. Mighell advises: "Develop such a convincing attitude of size-indifference that

the child will assume it for himself." He should be made to feel that size is as inconsequential as the color of hair or eyes; he must not consider himself the object of concern or special consideration.

The undersized child should have his rightful share of new clothes and not be expected to wear hand-me-downs. Second-hand clothing may become the insignia of the child's failure to keep pace in growth.

Special or double promotions in school are unwise for any child, but especially so for the "runt," the author believes. "It is bad enough to be a runt," she says, "without being singled out, derided, envied and otherwise persecuted as brainy."

The child should be provided with suitable hobbies as means of self-expression, but at the same time he should not be allowed to think that these opportunities are given him as a means of compensating for his handicap.

Pliofilm Aids Wet Dressings.—The difficulties of maintaining continuous wet dressings on the hands or feet in certain skin diseases are overcome by the use of mitts and socks made of a material called pliofilm, Dr. Garold V. Stryker and Dr. Joseph Grindon, Jr., St. Louis, report in *The Journal of the American Medical Association*.

"This material," they say, "is moisture proof, oil proof, odorless, nonirritating, pliable, thin, durable, tear-resistant, sewable, heat-sealing, not uncomfortably warm (as are rubber mitts and socks), noninflammable, resistant to weak acid and alkali, and inexpensive."

"Although rubber gloves and socks are effective for the purpose, patients object because of constriction and excess heat."

"In order to insure comfort the pliofilm coverings should be large enough to cover the dressings and at the same time permit some movement of the fingers and toes. To prevent drying, they must come in contact with the skin of the wrist or ankle above the dressings."

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Contra Costa County Medical Society President, Kaho Daily, 314 Tenth Street, Richmond. Secretary, Clifford E. Dietderich, 1306 Pomona Avenue, Crockett. Meeting, <i>Second Tuesday, 8:00 p. m.</i>	Napa County Medical Society President, Frank X. McGreane, Silverado Sanatorium, Calistoga. Secretary, M. M. Booth, Bruck Building, St. Helena. Meeting, <i>First Wednesday.</i>	Santa Clara County Medical Society President, Merlin T.-R. Maynard, 241 East Santa Clara Street, San Jose. Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose. Meeting, <i>Third Wednesday, 8:00 p. m., Medico-Dental Building, San Jose.</i>
Fresno County Medical Society President, Ray R. Dearhorn, First National Bank Building, Madera. Secretary, J. E. Young, 405 Rowell Building, Fresno. Meeting, <i>First Tuesday, University-Sequoia Club, Fresno.</i>	Orange County Medical Society President, John A. Wood, 605 No. Los Angeles Street, Anaheim. Secretary, Glenn Curtis, 323 North Pomona Street, Brea. Meeting, <i>First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.</i>	Santa Cruz County Medical Society President, A. F. Giberson, Watsonville. Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz. Meeting, <i>First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.</i>
Humboldt County Medical Society President, John N. Chain, Fourth and E Streets, Eureka. Secretary, Joseph S. Woolford, 350 E Street, Eureka. Meeting, <i>First Thursday.</i>	Placer County Medical Society President, William M. Miller, Auburn. Secretary, Robert A. Peers, Colfax. Meeting, <i>At Call of President.</i>	Shasta County Medical Society President, Clarence C. Gerrard, Redding. Secretary, Bertram L. Trelstad, 1536 Market Street, Redding. Meeting, <i>Second Monday.</i>
Imperial County Medical Society President, William A. Clarke, Holtville. Secretary, Claude F. Peters, 722 Main Street, Brawley. Meeting, <i>Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.</i>	Riverside County Medical Society President, Thomas A. Card, 3616 Main Street, Riverside. Secretary, W. Philip Corr, 3616 Main Street, Riverside. Meeting, <i>Second Monday, 8:00 p. m., Library, Riverside Community Hospital.</i>	Siskiyou County Medical Society President, Charles Pius, Yreka. Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka. Meeting, <i>Sunday on call.</i>
Inyo-Mono County Medical Society President, Lloyd S. Bambauer, 705 Home Street, Bishop. Secretary, Clarence L. Scott, 609 Elm Street, Bishop. Meeting, <i>Fourth Wednesday, Methodist Church, Bishop, except December, January, February.</i>	Sacramento Society for Medical Improvement President, Norris R. Jones, M. D., 1127 Eleventh Street, Sacramento. Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento. Meeting, <i>Third Tuesday, 8:30 p. m., Auditorium, Sacramento.</i>	Solano County Medical Society President, H. Randall Madeley, 727 Sonoma Street, Vallejo. Secretary, John W. Green, Box 539, Vallejo. Meeting, <i>Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.</i>
Kern County Medical Society President, C. S. Compton, 428 C Street, Bakersfield. Secretary, Eric F. Colby, Hopkins Building, Bakersfield. Meeting, <i>Third Thursday, 8:00 p. m.</i>	San Benito County Medical Society President, J. M. O'Donnell, Hollister. Secretary, L. E. Smith, Hollister. Meeting, <i>At Call of President.</i>	Sonoma County Medical Society President, S. Z. Peoples, 159 Kentucky Street, Petaluma. Secretary, T. E. Albers, 600 B Street, Santa Rosa. Meeting, <i>Second Thursday.</i>
Kings County Medical Society President, P. K. Edmunds, Corcoran. Secretary, William A. Johnstone, Hanford. Meeting, <i>Second Monday, 8:00 p. m., Legion Hall, Hanford.</i>	San Bernardino County Medical Society President, Walter S. Cherry, Rialto. Secretary, A. E. Varden, Medico-Dental Building, San Bernardino. Meeting, <i>First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.</i>	Stanislaus County Medical Society President, Richard D. Husband, P. O. Box 709, Modesto. Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto. Meeting, <i>Second Friday, 7:30 p. m., Hotel Hughson.</i>
Lassen-Plumas-Modoc County Medical Society President, W. B. McKnight, Portola. Secretary, Bernard S. Holm, Quincy. Meeting, <i>On Call.</i>	San Diego County Medical Society 1410 Medico-Dental Building, 233 A Street, San Diego President, Joseph Weinberger, Medico-Dental Building, 233 A Street, San Diego. Secretary, C. V. Bernardini, 1410 Medico-Dental Building, 233 A Street, San Diego. Meeting, <i>Second Tuesday, University Club.</i>	Tehama County Medical Society President, H. H. Beck, Corning. Secretary, F. J. Bailey, Red Bluff. Meeting, <i>At Call of President.</i>
Los Angeles County Medical Association 1925 Wilshire Boulevard, Los Angeles President, Roy E. Thomas, 1136 W. Sixth Street, Los Angeles. Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles. Meetings, <i>First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.</i>	San Francisco County Medical Society 2180 Washington Street, San Francisco President, William Reilly, 490 Post Street, San Francisco. Secretary, L. Henry Garland, 2180 Washington Street, San Francisco. Meetings, <i>Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.</i>	Tulare County Medical Society President, Ray E. Cronemiller, 160 South E Street, Exeter. Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia. Meeting, <i>Sunday Evening once a month.</i>
Marin County Medical Society President, Harry N. Hensler, Home Market Building, San Anselmo. Secretary, Carl W. Clark, 510 B Street, San Rafael. Meeting, <i>Fourth Thursday, 7:00 p. m., Marin Golf and Country Club.</i>	San Joaquin County Medical Society President, Hugh J. Bolinger, Farmers and Merchants Bank Building, Lodi. Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton. Meetings, <i>First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.</i>	Ventura County Medical Society President, Harry E. Barker, 1484 East Main Street, Ventura. Secretary, A. A. Morrison, 625 Main Street, Santa Paula. Meeting, <i>Second Tuesday, Ventura County Country Club.</i>
Mendocino-Lake County Medical Society President, Dallas L. Wagner, 615 Main Street, Fort Bragg. Secretary, Royal Scudder, Fort Bragg. Meeting, <i>On Call.</i>	San Luis Obispo County Medical Society President, F. W. Yocom, 732 Thirteenth Street, Paso Robles. Secretary, E. M. Bingham, County Health Department, San Luis Obispo. Meeting, <i>Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.</i>	Yolo County Medical Society President, Charles F. Keith, Williams. Secretary, W. J. Blevins, Jr., Woodland. Meeting, <i>First Tuesday.</i>
	Yuba-Sutter-Colusa County Medical Society President, Ben F. Miller, Yuba City. Secretary, Leon M. Swift, I. O. O. F. Building, Marysville. Meeting, <i>First Tuesday.</i>	

(Roster lists continued on advertising page 6)

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(Continued from Page 3)

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Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Insurance Association of Approved Hospitals, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; Easton Building, 428 Thirteenth Street, Oakland.

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Nevada State Medical Association

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Miscellaneous California Medical Organizations

Department of Public Health of the State of California San Francisco—State Office Building, McAllister and Larkin streets, UNDERHILL 8700. Sacramento—State Office Building, Tenth and L streets, CAPITAL 2800. Los Angeles—State Office Building, 217 West First Street, MADISON 1281. President, Elmer Belt, Los Angeles. Director, Bertram P. Brown, State Building, San Francisco.	Board of Medical Examiners of the State of California San Francisco, Rm. 214, 515 Van Ness Ave. Los Angeles, 906 State Building. Sacramento, Business and Professional Bldg., 1020 N Street. President, William R. Molony, Sr., Los Angeles. Secretary, C. B. Pinkham, Room 214, 515 Van Ness Avenue, San Francisco.	The Public Health League of California Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUTTER 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PROSPECT 5711. California State Department of Employment Headquarters Office: 1025 P Street, Sacramento; telephone Capitol 2800. Los Angeles Office: 1123 South Hill Street, telephone RICHMOND 4181. San Francisco Office: 154 Sansome Street, telephone EXbrook 5656. Competent personnel available through these offices. If in need of an office assistant, registered nurse, or office nurse, call the nearest office of the California Department of Employment.
California Northern District Medical Society President—John H. White, Chico. Secretary—J. Homer Woolsey, Woodland Clinic, Woodland.	Southern California Medical Association President, John C. Ruddock, 1930 Wilshire Boulevard, Los Angeles. Secretary, John B. Doyle, 501 Wilshire Medical Building, 1930 Wilshire Boulevard, Los Angeles.	

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 152)

The press and the business interests were unwilling that business should be injured by announcing to the world that plague existed in San Francisco. The public was asleep and ignorant of the danger that hung over the city. The number of infected rats had steadily increased, month by month, from 0.5 per cent in September, 1907, to more than 1.5 per cent in January, 1908. At this time the President of the State Medical Society requested the Council to appoint a committee to use the power of the profession to force publicity. The President was appointed chairman of such a committee and was empowered to choose his own committeemen. Drs. Jno. M. Williamson, H. M. Sherman, John Gallwey and Jas. H. Parkinson were appointed on this committee. After conference with those interested it was decided to call a mass meeting of those prominent in business and professional life. This was done. Six hundred invitations were sent—sixty citizens appeared at the meeting in the California Club Hall one night in January, 1908.

At this meeting a resolution was presented and passed, calling for the appointment of a Citizens' Health Committee of twenty-five. A few days later this committee was appointed by the Mayor, the President of the County Medical Society and the President of the State Medical Society. Thus was inaugurated the campaign against plague in San Francisco, the success of which requires no elaboration here. A few days afterwards a large mass meeting was held upon the floor of the Merchants' Exchange and the necessary publicity was obtained.

From an Original Article on "Statistics of My New Advancement Operation with Report of Cases," by Roderic

(Continued on Page 9)

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J. Lloyd Eaton, M.D., Oakland

TWENTY-FIVE YEARS AGO

(Continued from Page 7)

O'Connor, M.D., Oakland.—I do not intend to take up valuable time by giving a description of the operation. This has appeared in the journals on several occasions—the last and most complete being in the *Ophthalmic Record* for December, 1914. For the benefit of those who may not have seen any such account I will say that the object of the method is to avoid constriction of tissues by sutures and tension on sutures. This is done by looping marginal strips of tendon so as to form a double half hitch about a strand of catgut (20 or 40 day). This leaves a central tongue which is slack the amount of the marginal shortening. This central tongue can then be tucked, resected or actually advanced an amount equal to the marginal shortening and the suture holding it can be free from tension during the healing process. In view of the absence of constriction and tension, I claim the method to be mechanically and surgically correct in principle. . . .

From an Original Article on "President's Address Before the Sixteenth Annual Meeting of the American Therapeutic Society, San Francisco, Calif., June 21-22, 1915." *Some Observations on the Present Status of American Medical Journalism*, by Francis M. Pottenger, M. D., Monrovia. . . . I do not wish to be understood as criticizing individual journals as they now exist or have existed in the past, but I desire to point out the need, as I see it, for relieving our present unsatisfactory state of affairs. The *Journal* of the American Medical Association and the journals of many of our state associations are a credit to the profession, and are doing good work in both organization and teaching of scientific medicine; but no one can give more than a passing

(Continued on Next Page)

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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

glance to the situation without seeing that our American profession cannot be dependent upon these for their scientific education. These journals are, and should be, partly scientific in their nature, but they can never fully serve the needs of the American profession in scientific medicine; for their first function is to promote organization and improve the condition of medical men as a body. We need these journals for organization; but, aside from them, we need both general and special journals of national circulation and national interest, which, as they come to our table, will be representative of the best scientific work that is being done in all sections of the country. No one journal can do this, for the acquaintanceship and influence of every editor or editorial board is more or less circumscribed; but the field should be so well covered that, by taking several journals, the subscribers can keep breast of the present state of medical science. . . .

From an Original Article on "Gastro-Intestinal Symptoms in Diseases of the Circulatory System," by Dr. William Watt Kerr, San Francisco.—The relation between gastro-intestinal disorders and affections of the circulatory system is not infrequently overlooked, yet disturbed alimentation may be the only indication of weakened myocardium in elderly people or others who are not subjected to sufficient exertion to awake dyspnea, but whose poor circulation leads to portal congestion with its attendant dyspepsia and even more grave consequences.

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(Continued on Page 28)



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BOOK REVIEWS

BOOKS RECEIVED

Government and Economic Life. By Leverett S. Lyon and Victor Abramson. Paper. Pp. 66. Washington, D. C.: The Brookings Institution, 1940.

Mosquito Control. Practical Methods for Abatement of Disease Vectors and Pests. By William Brodbeck Herms, Sc. D., and Harold Farnsworth Gray, Gr. P. H. Cloth. Pp. 317. Price, \$3.50. New York: The Commonwealth Fund, 1940.

Influence of a Public Health Program on a Rural Community. Fifteen Years in Rutherford County, Tennessee, 1924-1938. By W. Frank Walker, Dr. P. H. and Carolina R. Randolph. Paper. Pp. 106. New York: The Commonwealth Fund, 1940.

Medical Nursing. By Edgar Hull, M. D., F. A. C. P., Clinical Professor of Medicine, Louisiana State University School of Medicine; Visiting Physician, Charity Hospital of Louisiana at New Orleans. Christine Wright, R. N., B. S., Graduate of Davis-Fischer Sanatorium, Atlanta, Georgia; Instructor of Nursing Arts, Charity Hospital School of Nursing, New Orleans, Louisiana, 1928-1939; Public Health Nursing, St. Mary Parish Health Unit and Experience Center, Franklin, Louisiana, 1939. Ann B. Eyl, B. S., Assistant Dietitian, Cook County School of Nursing, Chicago, Ill.; formerly Instructor in Home Economics, University of Kentucky, Lexington; Therapeutic Dietitian, Charity Hospital of Louisiana, New Orleans; Dietitian, St. Vincent's Infirmary, Little Rock, Arkansas. Cloth. Pp. 588, with 168 illustrations, including eleven color plates. Philadelphia: F. A. Davis Company, 1940.

Hugh Young: A Surgeon's Autobiography. With over 100 drawings by William P. Didusch and three color prints. Cloth. Pp. 554. Price, \$5.00. New York: Harcourt, Brace and Company, 1940.

Getting Ready to Be a Mother. By Carolyn Connant Van Blarcom, R. N. Revised by Hazel Corbin, General Director Maternity Center Association. Fourth Edition. Cloth. Pp. 190, illustrated. Price, \$2.50. New York: The Macmillan Company, 1940.

Applied Pharmacology. By Hugh Alister McGuigan, Ph. D., M. D., F. A. C. P., Professor of Pharmacology and Therapeutics, University of Illinois. College of Medicine. Cloth. Pp. 914, illustrated. Price, \$9.00. St. Louis: The C. V. Mosby Company, 1940.

The Bacteriology of Public Health. By George M. Cameron, Ph. D., Associate Professor of Bacteriology. University of Tennessee. Cloth. Pp. 451. Price, \$3.50. St. Louis: The C. V. Mosby Company, 1940.

Diseases of the Digestive System. A Textbook for Students and Practitioners. By Eugene Rosenthal, M. D., Lecturer in the Medical Faculty, Royal Peter Pázmány University, Budapest, Hungary. With a Preface by R. J. V. Pulvertaft, M. D., F. R. C. P., Reader in Pathology, University of London; Director of the John Burford Carllill Laboratories and Curator of Museum, Westminster Hospital School of Medicine. Cloth. Pp. 394, with 234 illustrations, including 104 in color, and 16 tables. Price, \$8.50. St. Louis: The C. V. Mosby Company, 1940.

The Rockefeller Foundation Annual Report, 1939. Paper. Pp. 507, illustrated. New York: The Rockefeller Foundation, 1940.

Manson's Tropical Diseases. A Manual of the Diseases of Warm Climates. Edited by Philip H. Manson-Bahr, C. M. G., D. S. O., M. A., M. D., D. T. M., and H. Cantab., F. R. C. P., Lond., Senior Physician to the Hospital for Tropical Diseases, London, the Albert Dock Hospital and the Tilbury Hospital; Consulting Physician to the Colonial Office and Crown Agents for the Colonies; Consultant in Tropical Diseases to the Royal Air Force, etc. Eleventh Edition. Revised. Cloth. Pp. 1083, with 18 color plates, 15 half-tone plates, 364 figures in the text, 6 maps, and 28 charts. A William Wood Book. Baltimore: The Williams & Wilkins Company, 1940.

BOOK REVIEWS

The 1939 Year Book of Dermatology and Syphilology. Edited by Fred Wise, M. D., Clinical Professor of Dermatology and Syphilology, New York Postgraduate Medical School and Hospital of Columbia University; Member of the American Dermatological Association, Inc., and Marion B. Sulzberger, M. D., Assistant Clinical Professor of Dermatology and Syphilology, New York Postgraduate Medical School and Hospital of Columbia University; Member of the American Dermatological Association, Inc. Cloth. Pp. 740, illustrated. Price, \$3.00. Chicago: The Year Book Publishers, Inc., 1940.

This is an attractive well-bound book of over 700 pages and more than 100 photographs. The dermatological advances made during the year in methods of diagnosis, therapeutic procedures, investigative studies and special techniques are herewith presented, having been gathered from the literature all over the scientific world. Thus, the various articles are abstracted and grouped with others in their own field. The topics covered include forms of medication and vehicles, mycotic infections, allergy and immunology, eczema and dermatoses, including industrial types, drug eruptions, cancers and other tumors, chronic granulomas other than lues, leukemias, venereal diseases other than syphilis, and the latest in the therapy of syphilis.

Advances in the use of sulfanilamide and related compounds in skin therapy, the use of vitamins in pellagra and other skin conditions, and physical therapy are all well covered. Investigative studies have been made to clear up the immunological principles of cutaneous sensitization.

(Continued on Next Page)



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BOOK REVIEWS

(Continued from Preceding Page)

In summary, this book is a ready, up to date reference medium not only for the general practitioner who wants to keep abreast of medical research, but also for the dermatologist, allergist and pediatrician whose fields so often merge with dermatology. It should be very useful in any physician's library.

R. L. K.

Handbook of Orthopedic Surgery. By Alfred Rives Shands, Jr., B. A., M. D., Medical Director of the Nemours Foundation, Wilmington, Delaware; Associate Professor of Surgery in Charge of Orthopedic Surgery, Duke University School of Medicine, Durham, North Carolina (on leave of absence). In collaboration with Richard Beverly Raney, B. A., M. D., Associate in Orthopedic Surgery, Duke University School of Medicine. Illustrated by Jack Bonacker Wilson. Cloth. Pp. 567. Price, \$4.25. St. Louis: The C. V. Mosby Company, 1940.

This book should be available to all physicians and surgeons. The subject matter is covered completely, and in an easily understood manner. The absence of voluminous historical data ordinarily found in texts is a refreshing change. The reader does not need to be an orthopedist to understand the subject matter. This fact makes it valuable to the general practitioner.

N. K. B.

Synopsis of the Principles of Surgery. By Jacob K. Berman, A. B., M. D., F. A. C. S., Assistant Professor of Surgery, Indiana University School of Medicine, Indianapolis. Cloth. Pp. 615, with 274 illustrations. Price, \$5.00. St. Louis: The C. V. Mosby Company, 1940.

The text opens with an excellent historical review of surgery from 4500 B. C. to the present day. An introduction of this sort at once interests me in a medical work as it always seems that an author who begins his work in this way treats his subject with the same thoroughness one might expect.

On page 29 under Vital Staining, making a drill hole in the sternum for aspiration of bone marrow is mentioned. I believe that puncture with a large needle at the second interspace is used now instead of the more formidable drill opening. This seems like a trivial matter, but if one has

been obliged to make a drill opening in a child very ill with leukemia, for instance, any method that is less severe I am sure will be gratefully accepted. The book is well arranged and the subject material is clearly presented. The illustrations, consisting of original charts, diagrams, photographs, and micro-photographs, are of unusual excellence.

It is a relief to look through the illustrations and see only original work. The 600 pages are compressed into a small volume and the semi-flexible binding makes it very easy to handle. Although written principally for medical students, the book may well be in the library of every practitioner of medicine. It represents an enormous amount of careful, painstaking work and contains much valuable reference material.

C. M. F.

The Rise of Embryology. By Arthur William Meyer, Professor of Anatomy, Emeritus, Stanford University. Cloth. Pp. 367. Price, \$6.00. Stanford University: Stanford University Press, 1939.

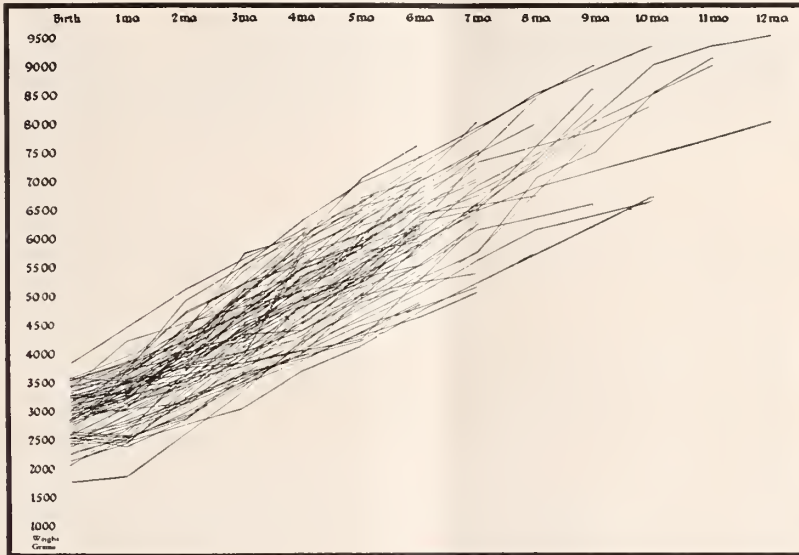
If one were to follow the custom of a few generations ago we could well entitle this book "A Philosophy of the Growth of Scientific Thought as Portrayed in a Study of the Rise of Embryology." Doctor Meyer has skillfully woven a history of man's painful efforts to solve the great question of the "why" that stares us in the face as illustrated by the growth of our knowledge of embryology. Beginning with the naive ideas of aboriginal man we are brought up to the present along the winding paths of simple, child-like explanation, pseudo-science, and what we now think is real science. "There's a long, long trail a-winding" from what the Neanderthal Man thought about the reproduction of species to what is the accepted theory now. Doctor Meyer has led us along that path weaving together much original literature and his own clear interpretation.

This book may well be regarded as a crystallization of all that has been said or thought in the past about reproduction. It marks another milestone in scientific and even philosophical literature. The reviewer has appreciated the opportunity of renewing an acquaintanceship with a former professor and sincerely hopes that he who, in the future, may write the continuation of Doctor Meyer's story will deal as kindly and sympathetically with our foibles and failures as he has done with those who have gone before.

W. H. G., Jr.

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 16)

The Endocrine Therapy in General Practice. By L. Sevringhaus, M. D., F. A. C. P., Professor of Medicine, University of Wisconsin, Madison, Wisconsin; Editor, Department of Endocrinology, The Year Book of Neurology, Psychiatry and Endocrinology. Cloth. Pp. 239. Price, \$2.75. Chicago: The Year Book Publishers, Inc., 1940.

Much needed, concise information on Endocrine Therapy in general practice is presented by Doctor Sevringhaus.

Therapeutic detail and comparison of various commercial products in a manner that will help the busy general practitioner who cannot be conversant with different names for identical products manufactured by leading pharmaceutical houses are valuable contributions. Doctor Sevringhaus brings forcefully to one's attention the relation to an optimum vitamin intake to the adequate functioning of the endocrine system.

The chapter on Endocrine Problems of Children should be carefully studied by everyone who practices medicine. No one chapter can be recommended more highly than another, however, for each is dealing with advanced scientific research, yet the material is presented in masterful simplicity. M. W.

Modern Dermatology and Syphilology. By S. William Becker, M. D., Associate Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago, and Maximilian E. Obermayer, M. D., Assistant Professor of Dermatology and Syphilology, Kuppenheimer Foundation, University of Chicago. Cloth. Pp. 871, with 461 illustrations in text and 32 full color plates. Price, \$12. Philadelphia: J. B. Lippincott Company, 1940.

Doctors Becker and Obermayer have, in this volume, made available to the medical profession a work that will be of great value to all who are interested in dermatology. Because of the arrangement of the material in each chapter and the clear and intimate style in which it is presented, and because of the excellent chapter on Therapy, this book should find frequent use by the nondermatologic practitioner of medicine.

The undergraduate medical student will find the paragraphs at the beginning of each chapter under the heading "Orientation" a means of getting a good picture of the group of diseases to be discussed before the detailed discussions are made.

The dermatologist will find this book a valuable asset to his library especially from the standpoint of therapy outlined in Chapter 4. Chapter 10 on neurodermatoses will probably prove most in-

teresting to dermatologists and it should be read several times. Chapter 35 is especially valuable to dermatologists.

All of the illustrations are excellent and the color plates are of inestimable value to a dermatologic treatise like this.

The chapters on syphilis give a comprehensive picture of the present-day conception of this disease and the problems which it presents. The folding chart between pages 814 and 815 contains much valuable information, but it is my feeling that such a presentation loses much of its value because of the inconvenience in handling. The same information in chart form on pages of the book would be far more accessible.

This publication may be readily recommended as a text or as a reference book. J. C. H., Jr.

Maternal Care and Some Complications. The Principles of Antepartum, Intrapartum, and Postpartum Care and of the Management of Some Serious Complications. Approved by The American Committee on Maternal Wel-

(Continued on Page 20)



Noah Webster might have written his definition of research with Parke-Davis in mind

Research is diligent, protracted investigation, especially for the purpose of adding to human knowledge.—

N. Webster

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BOOK REVIEWS

(Continued from Page 18)

fare, Inc. F. L. Adair, M. D., Editor. Cloth. Pp. 194. Price, \$1.50. Chicago: The University of Chicago Press, 1939.

This small volume, edited by F. L. Adair, has been prepared under the auspices of the American Committee on Maternal Welfare with the purpose of helping those engaged in the care of mothers and their infants to lessen the morbidity and mortality among their patients, and to raise the quality of maternal and infant care to the highest possible level.

The various chapters have been prepared by leading obstetrical authorities, and the material and manuscript approved by representatives of most of the medical organizations of the American Committee on Maternal Care.

It deals in no theoretical considerations, but gives in careful and minute detail the essentials of proper antepartum, intrapartum and postpartum care. It gives a complete history outline, details of the physical examination, including pelvimetry, and the necessary laboratory procedures. The follow-up examinations are discussed and careful instruction for the patient in the hygiene of pregnancy, including diet, clothing, exercise and other essentials. Technique of intrapartum care, including indications and contraindications for the various operations, and the use of oxytocic drugs, is discussed in great detail and likewise the postpartum care is fully outlined.

The three major complications, emesis and the toxemias of pregnancy, obstetric hemorrhages, and puerperal infection are each given a chapter.

The advice given in this small manual is sound, amazingly complete, and if carefully followed should do much to accomplish its avowed purpose.

Medical Entomology. With Special Reference to the Health and Well-Being of Man and Animals. By William B. Herms, Professor of Parasitology in the University of California, Consulting Entomologist for the California State Board of Health, Honorary Member of National Malaria Committee. Third Edition, based on the book known as "Medical and Veterinary Entomology," Cloth. Pp. 582. Price, \$5.50. New York: The Macmillan Company, 1939.

This up-to-the-minute revision of Professor Herms' authoritative "Medical and Veterinary Entomology," while primarily a textbook for medical entomologists, is an excellent reference work for physicians and veterinarians. It is a necessity for health officers and sanitarians. The epidemiological information, preventive measures and procedures in treatment are succinct and accurate. The arrangement of the content allows for all degrees of knowledge. The detailed descriptions of the insects and arachnids will be too technical for most of the readers except the entomologists; however, those physicians who possess sufficient background can actually identify the miscreant which has nipped the patient when the latter brings it into the office in the usual mayonnaise jar.

The author first presents a brief historical review, followed by a stimulating discussion of the general scope of

(Continued on Page 22)

BRIEF HISTORICAL NOTES ON MEAD'S CEREAL AND PABLUM

HAND in hand with pediatric progress, the introduction of Mead's Cereal in 1930 marked a new concept in the function of cereals in the child's dietary. For 150 years before that, since the days of "pap" and "panada," there had been no noteworthy improvement in the nutritive quality of cereals for infant feeding. Cereals were fed principally for their carbohydrate content.

The formula of Mead's Cereal was designed to supplement the baby's diet in minerals and vitamins, especially iron and B₁. How well it has succeeded in these functions may be seen from two examples:

(1) As little as one-sixth ounce of Mead's Cereal supplies over half of the iron and more than one-fifth of the vitamin B₁ minimum requirements of the 3-months-old bottle-fed baby. (2) One-half ounce of Mead's Cereal furnishes all of the iron and two-thirds of the vitamin B₁ minimum requirements of the 6-months-old breast-fed baby.

That the medical profession has recognized the importance of this contribution is indicated by the fact that cereal is now included in the baby's diet as early as the third or fourth

month instead of at the sixth to twelfth month as was the custom only a decade or two ago.

In 1933 Mead Johnson & Company went a step further, improving the Mead's Cereal mixture by a special process of cooking, which rendered it easily tolerated by the infant and at the same time did away with the need for prolonged cereal cooking in the home. The result is Pablum, an original product which offers all of the nutritional qualities of Mead's Cereal, plus the convenience of thorough scientific cooking.

During the last ten years, these products have been used in a great deal of clinical investigation on various aspects of nutrition, which have been reported in the scientific literature.

Many physicians recognize the pioneer efforts on the part of Mead Johnson & Company by specifying Mead's Cereal and PABLUM.

Pablum is a palatable mixed cereal food, vitamin and mineral enriched, composed of wheatmeal (farina), oatmeal, cornmeal, wheat embryo, beef bone, brewers' yeast, alfalfa leaf, sodium chloride, and reduced iron.

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I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$——, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

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FORM OF CLAUSE OF WILL PROVIDING FOR BEQUEST OF PERSONAL PROPERTY

I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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BOOK REVIEWS

(Continued from Page 20)

the field of parasitism of arthropods and diseases. Then he provides the morphological and developmental descriptions necessary for classification. The remainder of the book systematically considers the various arthropods of importance to the health of man and animals. A general description of each of the groups is followed by the detailed description and the key for classification. With the more important insects the broad view of the economic and health significance precedes these more technical discussions. A complete review of the medical rôle of the group and its members is presented, with special emphasis on the experimental methods of entomology which have proved the relation of the insect to disease. Herms has assembled such classics as the report of the Yellow Fever Commission, the studies of Theobald Smith and of Ricketts, as well as less spectacular discoveries which are equally instructive in methodology of medical entomology.

The fact that Professor Herms is a Californian insures the deserved emphasis on such insect-borne diseases of the West as tularemia, Rocky Mountain spotted fever, relapsing fever, plague and malaria, in addition to our pest insects and such potential enemies of man as our "kissing bug" (conenose or reduvid), with its threat of trypanosomiasis. The control measures especially suitable for the West are also stressed.

The illustrations are profuse and excellent. They include not only the arthropods themselves, but also outline the practical control measures. Again one observes a very helpful western flavor.

At the end of each chapter is a complete list of references for statements in the text. The index is so complete that even the authors of these references are included. The text is remarkably free of errors. A very minor criticism is that, as long as pellagra is mentioned as not being spread by the buffalo gnat, more information might be given regarding present vitamin knowledge than the statement (p. 140) that pellagra is "dependent on some yet undetermined fault in knowledge." Medical readers do not need this additional knowledge, but many will be student entomologists, sanitarians, and others not abreast of more

(Continued on Page 25)

NEW STUDY*—AGAIN PROVES THE VALUE OF COCOMALT

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*Medical Record, August 21, 1940

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BOOK REVIEWS

(Continued from Page 22)

recent developments. A similar criticism might be made regarding the consideration of human equine encephalomyelitis, which dismisses the subject with this sentence: "Man is evidently susceptible to the infection." The book is so thorough and complete, even in its medical aspects, that one expects the final word throughout.

One may summarize by stating that Professor Herms has admirably performed the service of specialist scholar. He has taken the maze of detail and personal experience and, by means of his broad background, focused this bewildering, overwhelming amount of information into a well-balanced, authoritative book which is understandable and, to the reviewer at least, actually enjoyable! C. E. S.

Obstetrical Practice. By Alfred C. Beck, M. D., Professor of Obstetrics and Gynecology, Long Island College of Medicine; Obstetrician and Gynecologist-in-Chief, Long Island College Hospital, Brooklyn. Second Edition. Cloth. Pp. 858, with more than one thousand illustrations. Price, \$7. Baltimore: The Williams & Wilkins Company, 1939.

As stated by the author in the preface, the second edition has been revised and brought up to date on the subjects of physiology of reproduction, toxemia and abortion, and complications of pregnancy. These changes are in keeping with the times and require no further comment.

From the obstetrician's point of view, the text, though didactic, is admirably suited to the general practitioner as a quick source of information on the constantly recurring problems of obstetrics. Avoidance of controversial theories and methods of treatment greatly simplify the text.

There are two chapters in particular the reviewer wishes to mention. The first, on retained and adherent placentae, is new and covers in concise fashion the diagnosis and treatment of these abnormalities. The other chapter is on contracted pelvis (Chapter XXX). Pelvimetry and the interpretation of pelvic measurements are the pitfall of many in general practice, largely due to inadequate teaching and experience in medical school. The author has com-

bined the more modern interpretation of the female pelvis, as advanced by Caldwell and Moloy, with the conventional teaching in such a way that this chapter should be of aid to those to whom pelvimetry is clouded with uncertainty.

Illustrations are profuse and, though diagrammatic, are adequate. The discussion of obstetric surgery is rather brief, but this is as it should be, since surgical procedure must be learned at the operating table and not from the pages of a book.

To reiterate, the reviewer would recommend this book to the general practitioner as a good source of information for the majority of obstetrical problems. H. G. W.

The Dysenteric Disorders. The Diagnosis and Treatment of Dysentery, Sprue, Colitis and Other Diarrheas in General Practice. By Philip Manson-Bahr, C. M. G., D. S. O., M. D., F. R. C. P., Senior Physician to the Hospital for Tropical Diseases, London; Director, Division of Clinical Tropical Medicine, London School of Hygiene and Tropical Medicine; Consulting Physician to the Colonial Office and Crown Agents for the Colonies. With an Appendix by W. John Muggleton, M. S. M., Technical Assistant. Cloth. Pp. 613, with 9 color and 14 black-and-white plates, and 106 illustrations in the text. Price, \$8. Baltimore: The Williams & Wilkins Company, 1939.

There has been great need for such a volume as this, written from the standpoint of the general practitioner, and covering the entire field authoritatively; and no one is better fitted by experience and critical judgment for its writing than Philip Manson-Bahr. One might wish the author's judgment had been exercised rather more critically in the discussions of various methods of treatment toward a sharper evaluation. Also, we have become accustomed to insufficient recognition of American research and its clinical applications in the medical literature, both of England and the continent.

The subject index covers adequately and systematically the bacillary, helminthic and protozoal dysenteries, infective diarrheas (the typhoids, food poisoning and cholera), steatorrheas, other types of colitis and the diarrheas such as regional enteritis, lymphogranuloma, foreign bodies, in-

(Continued on Next Page)

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BOOK REVIEWS

(Continued from Preceding Page)

tussusception, diverticulitis, tuberculous and syphilitic lesions, actinomycosis, polyps, and cancer. The volume is well illustrated, in the excellent manner of the author. The appendix provides a good practical review of methods of diagnosis, with tables and exact directions making adequate examination possible by the medical man inexperienced in laboratory technique when he does not have proper technical assistance available. Again, directions might well have been simplified to the exact procedures approved by the author. Not the least excellent feature of the volume is the splendid indexing.

On the whole, this book is an invaluable reference work for every physician who sees clinical disorders of the intestinal tract. In its use the American physician will keep in mind certain differences in treatment and diagnostic method which have been found practical and successful in this country.

A. C. R.

Epidemic Encephalitis. Etiology, Epidemiology, Treatment. Third Report by the Matheson Commission, Willard C. Rappleye, Chairman. Cloth. Pp. 493. Price, \$3. New York: Morningside Heights: Columbia University Press, 1939.

This third report of the Matheson Commission brings up to date the review of the work done on the encephalitides. The material is well organized and covers research and publications from all over the world. A complete bibliography of the reviewed articles is given.

H. E. T.

Elmer and Rose Physical Diagnosis. Revised by Harry Walker, M.D., F.A.C.P., Associate Professor of Medicine, Medical College of Virginia, Richmond, Virginia. Eighth Edition. Cloth. Pp. 792, with 295 illustrations. Price, \$8.75. St. Louis: The C. V. Mosby Company, 1940.

The eighth edition of this book is a complete and well-illustrated volume of 792 pages, divided into two parts. Part I confines itself to the technique of examination. Part II deals with the physical diagnosis of disease, particularly cardiac and respiratory diseases. A supplementary section on diagnostic procedures, such as electro-

cardiography, is a valuable adjunct. The chapter on the neuropsychiatric examination is exceptionally well written.

This text will be of most value to the student as a supplement to a lecture course in physical diagnosis. The initiate may thus be aided in separating wheat from chaff.

The practitioner will find this book valuable for reference or purposes of review.

R. A. O.

Surgical Applied Anatomy. By Sir Frederick Treves, Bart. Tenth Edition. Revised by Lambert Rogers, M.Sc., F.R.C.S., F.R.C.S.E., F.R.A.C.S., F.A.C.S., Professor of Surgery, University of Wales; Honorary Surgeon and Director of the Surgical Unit, Cardiff Royal Infirmary; Formerly Hunterian Professor, Royal College of Surgeons of England; Reader in Surgery, University of London; Examiner in Anatomy to the Conjoint Examining Board in London, and Prosector to the University of London. Cloth. Pp. 748, illustrated with 192 figures, including 66 in color. Price, \$4.50. Philadelphia: Lea & Febiger, 1939.

Originally this book was prepared for use of students preparing for final examination in surgery and as an aid in the dissecting room. However, the present edition seeks to correlate anatomy and surgery so that the surgeon is always mindful of the anatomy involved. The book is written entirely from the surgical point of view, and because of this is much more interesting reading than one would expect from a small handbook. The text covers the entire anatomy of the body and sections on eye, ear, nose and throat, and the genito-urinary organs have been rewritten with the aid of specialists.

I believe this to be a very worth-while book for the general practitioner as well as for the student. It is of handbook size and by necessity does not go into too great detail. Although written by British authors, the nomenclature is in keeping with common American diction. The printing is excellent and easily readable. Because of the compactness of the volume, the number and size of the illustrations have had to be curtailed, although there are a good number of fine illustrations.

The student and general practitioner should find this handbook worthy of wide use, but I doubt if there is sufficiency of detail to satisfy the specialist.

F. A. C.

(Continued on Page 28)

STUDIES IN THE AVITAMINOSES



This page is the ninth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the August 17 issue of The Journal of the American Medical Association.



Casal's collar in a patient with advanced pellagra secondary to chronic alcoholism.

Illustration courtesy of Virgil P. W. Sydenstricker, M.D., University of Georgia Medical School, Augusta.

The scaling symmetrical pellagrous dermatitis of the hands.



The Dermatitis of Pellagra

The severe scaling dermatitis of the hands seen in most cases of advanced pellagra is pathologically identical with skin lesions developing elsewhere on the body surface. Microscopically, thickening of the skin, lymphocytic infiltration of the dermis, and hyaline degeneration of the intima of the smaller arterioles are observed. The early clinical changes consist of burning, tenderness, erythema, pigmentation, and mild vesiculation. The acute character of the eruption disappears after a variable period but if no treatment is instituted, the pigmentation becomes more intense and the scaling and desquamation

more severe. As with other pellagrous skin lesions, the dermatitis of the hands is bilateral and symmetrical, and is sharply demarcated from the adjacent normal skin.

The dermatitis which frequently appears on the neck is known as Casal's collar. The lesion assumes its peculiar distribution because of the provocative action of sunlight upon the skin of pellagrins. The neck, exposed to the influence of sunlight, is thus frequently the site of the pellagrous dermatitis. However, unexposed portions of the skin, notably the upper thighs and perineum, may become similarly involved.



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BOOK REVIEWS

(Continued from Page 26)

Atlas of Surgical Operations. By Elliott C. Cutler, Moseley Professor of Surgery, Harvard University and Chief Surgeon of the Peter Bent Brigham Hospital; Formerly Professor of Surgery, Western Reserve University, and Director of Surgery of the Lakeside Hospital, and Robert Zollinger, Assistant Professor of Surgery, Harvard University and Senior Associate in Surgery at the Peter Bent Brigham Hospital. Cloth. Pp. 180. Illustrated by Mildred B. Coddling. Price, \$8. New York: The Macmillan Company, 1939.

This surgical atlas is designed to meet the needs of the young surgeon and of the surgical residents of hospitals, particularly those not connected with a medical school. The most common general surgical procedures are both illustrated and discussed, using simple but concise plates with accompanying brief descriptions of the essential steps involved. The important anatomical and surgical features of each operation are clearly stressed. In addition, there is a brief outline of the indications for surgery, preoperative care, anesthesia and postoperative care. From the standpoint of operative surgery, this atlas meets a need not covered by even the larger texts. One can readily refresh one's mind on any surgical procedure with the least expenditure of time. There are certain details ordinarily left to the nursing staff, and for this reason the book would be useful in the instruction of surgical nursing.

The Atlas of Surgical Operations would be a very useful supplement in the library of any doctor engaged in general practice, or in the instruction of surgery in a general hospital. The illustrations alone are well worth the attention of the surgeon.

W. E. M.

Clinical Toxicology. By Clinton H. Thienes, M. D., Ph. D., Professor of Pharmacology and Head of the Department of Pharmacology, School of Medicine, University of Southern California, Los Angeles; Attending Pathologist (Toxicology), Los Angeles County Hospital. Cloth. Pp. 399, illustrated. Price, \$3.50. Philadelphia: Lea & Febiger, 1940.

This is an instructive and up-to-date compilation of the subject. The author has organized the material according to the clinical manifestations of the toxic agents in a

manner which will be of service to the student and to the clinician.

Drugs are grouped according to their major site of action and clinical symptomatology. In the first six sections (Convulsant Poisons, Central Nervous System Depressants, Peripherally Acting Nerve Poisons, Muscle Poisons, Protoplasmic Poisons, and Poisons of the Blood) each drug is discussed concisely yet fully as to toxic dose, source and chemistry, absorption, etiology of poisoning, symptoms and actions, fate and excretion, pathology, diagnosis, cause of death, and treatment. The next two sections, principles of treatment and an outline of symptom diagnosis, discuss the broader aspects and integrate the preceding materials in a manner designed as a diagnostic aid. The last section deals with chemical diagnosis of poisoning, containing the most practical and specific methods of detection, and will be a distinct asset in any well equipped laboratory.

P. M.

TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 10)

of the liver, pancreas, stomach and intestines, so that the function of all these organs is seriously impaired; but there is another group of cases from which edema and valvular murmurs may be entirely absent, where the trouble lies in changes that have taken place in the blood vessels and cardiac muscle as part of the ordinary senile degeneration, or in consequence of disease or dietetic excesses; and these are not so readily recognized. . . .

From an Original Article on "Benzene Treatment of Leukemia," by W. W. Boardman, M. D., San Francisco.— Of the etiology of the leukemias, we know nothing. The essential morbid process is an excessive and abnormal activity of the leukoblastic tissues of the body, manifested by an increase in the number and an alteration in the character of the circulating leukocytes. A specific remedy would destroy the unknown exciting factor, be it toxic, infectious or

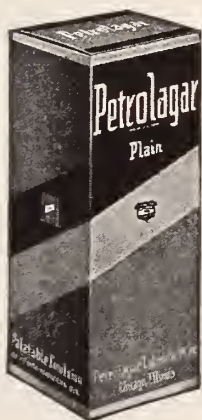
(Continued on Page 30)



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San Francisco

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

what not. Lacking this, our therapeutic efforts are limited to attempts to control the excessive activity of the leukoblastic tissues. For this purpose, arsenic has for years been used; more recently the x-ray, radium and thorium x have been added. With each and all of these measures, striking improvement may occur, but with none do permanent cures result. New hopes were therefore raised by Koranyi's report in 1912 of the striking effect obtained with benzol. . .

From an Original Article on "The Blood in Leukemia," by H. R. Oliver, M. D., San Francisco. From the Serological Laboratory of the Stanford University Medical School.—Leukemia is a malignant (idiopathic) hyperplasia affecting the leukocytic forming tissues, which results in an enormous increase in the production of the white blood corpuscles. This hyperplasia may affect only one type of cell, and there may even be a diminution of the other varieties of leukocytes, or there may be an increase of all varieties, with one type considerably more than the others.

Hughes Bennet, in 1845, described a case of suppuration of the blood or leukocythemia. A short time after 1845 Vichow described a case and gave it the name "leukemia." It was not, however, until some time later that Ehrlich, by his new method of staining, showed that in the two types the cells were different.

The leukemias were formerly divided, according to their clinical aspects, into the lymphatic, splenic, spleno-medullary, and medullary or myelogenous forms. This has given way to the hematological one of Ehrlich of lymphatic and myeloid, based upon the kind of cell proliferation. . .

From an Original Article on "Roentgen Ray Treatment of Leukemia," by Howard E. Ruggles, M. D., San Francisco.—Since the cases of Schultz in 1901, Pusey in 1902, and Senn in 1903, the reported cases of leukemia treated with Roentgen rays run well into the thousands.

The usual results are more or less rapid improvement in general condition, lowering of white count, and return of differential count to normal. Subsequent relapses are common and are usually difficult to control. Faithful persistence with the treatment and intelligent dosage diminish the possibilities of relapse. There are a good many records of patients who have been symptomatically well for periods of over five years. Contraindications are: (1) acute type; (2) presence of increasing anemia, cachexia, or fever. . .

From an Original Article on "The Routine Examination in a General Hospital for Diphtheria Carriers and a Note on the Schick Reaction," by W. T. Cummins, M. D., Philip King Brown, M. D., and C. L. Bittner, M. D., Harriman Laboratory, Southern Pacific General Hospital, San Francisco.—Modern medicine has made no advance more important than that concerning the prevention of disease. The eradication of yellow fever in Havana is a brilliant example of the potency of prophylaxis. Vaccination, the study of water supplies and sewage disposal, and other hygienic measures have had a marked effect in reducing the morbidity of typhoid fever. The dissemination of certain infections, of known and unknown etiology, is brought about in many instances by the harboring in the tissues of the recovered individual or of the healthy "contact" the infectious agents. Notable among these diseases are typhoid fever, epidemic meningitis, diphtheria and, probably, pneumonia and po-

(Continued in Back Advertising Section, Page 34)

THE HUMAN NEED FOR IODINE

● Like calcium and iron, iodine is commonly considered as an essential mineral which may be supplied in suboptimal amounts by American diets. Unlike calcium and iron, the human daily requirement for iodine cannot be as closely approximated as can the human needs for those two minerals.

Many researches (2) have established that a deficiency of iodine in food and water may produce a derangement of the thyroid gland known as simple or endemic goiter. The management of this condition, once present, is properly a matter for competent medical attention. However, it is agreed that normally the prevention of endemic goiter is purely a nutritional problem and that control of this disorder can be effected by providing for an adequate daily supply of iodine. It has been suggested (1, 2) that the probable human iodine requirement lies between 0.05 and 0.10 milligram per day, the higher amount being indicated for children and for pregnant and lactating women.

Due to the fact that the foods and water in certain regions—especially the so-called “goiter belt”—are low in iodine content,

obviously some means of enhancing the iodine intake of persons residing in such localities should be provided. For this purpose, iodized salt has been proven most effective and is commonly favored for use under such circumstances (3). However, the low incidence of endemic goiter in seaboard localities—in which the plant and animal foods are exceptionally high in iodine—suggests the potential value of food sources of iodine.

Under normal circumstances, in goiterous regions, main dependence should be placed on iodized salt as a source of iodine. However, the value of foods high in content of this essential mineral should not be overlooked. As indicated above, foods grown in the coastal areas are exceptionally high in iodine; in addition, fish and marine products from coastal waters are also rich food sources of this element. Consequently, such foods—many of which are available as commercially canned foods—should serve as economical and convenient supplementary sources of iodine. Through intelligent use of iodized salt and the available food sources of iodine, an optimal daily supply of this dietary essential should readily be obtained.

AMERICAN CAN COMPANY

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REFERENCES

(1) 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York, N. Y.

(2) 1939. Food & Life, Yearbook of Agriculture, U. S. Dept. of

Agriculture, U. S. Govt. Printing Office, Washington, D. C.

(3) 1939. General Decisions, Council on Foods, Amer. Med. Assoc., Chicago.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-third in a series, which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

"MEDICAL PREPAREDNESS"

Impending Events, and the Rôle of the Medical Profession.—As the days go by, it becomes more and more apparent that the United States must be prepared for military eventualities which, by the great majority of citizens, were not even thought of a few years ago. The current changes in the map of Europe, due to realignments of peoples and nations, as well as other transformations in international relationships, some impending and others possible within the near future, have made the majority of American citizens more or less war-conscious. Since war is in the air, therefore, it follows that proposed laws concerning selective service, with discussions thereon in Congress, are natural consequences.

Any form of selective service, for whatever age periods may be decided, brings into consideration, almost from the very beginning, the classification of citizens according to two groups: one, whose members will be assigned to military ranks, and the other, those for designated civil activities. In each, however, early decision as to physical and mental fitness must be made. Much of that responsibility of determining who shall and who shall not be assigned to this or the other group will fall upon members of the medical profession.

* * *

American Medical Association Questionnaires Must Be Forwarded.

—Last month's issue of CALIFORNIA AND WESTERN MEDICINE gave an outline on pages 86 and 87 and elsewhere of the Federal and State plans regarding medical preparedness as contemplated in the plans for California. Since any form of national selective service must emanate from the congressional halls in Washington, it follows that basic dicta of the national military and civil authorities will be paramount.

National and State Committees on Medical Preparedness will be called upon, no doubt, in due course to be of very definite service. Through arrangement with the military arms of the Government, the American Medical Association has taken the first important step in the important work by circularizing the entire medical profession, sending to every physician a questionnaire which, after be-

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

ing filled in and transmitted to the American Medical Association Committee on Medical Preparedness, at 535 North Dearborn Street, Chicago, will give to the Association the essential data—in so far as possible service by physicians is concerned—it, in turn, may be called on to forward to the authorities at Washington.

Every member of the California Medical Association owes it to himself and to the California Medical Association to forward his questionnaire. If the blank has been mislaid or otherwise lost, a request sent to the American Medical Association will bring a duplicate. For such cooperation the California Medical Association Committee on Medical Preparedness—of which Dr. Philip K. Gilman, of San Francisco, is chairman—will be most appreciative.

* * *

California State Council of Defense.—The "California State Council of Defense" is an independent State effort, brought into being by Governor Culbert Olson, who appointed a committee of fifty citizens to supervise the alignment of California's resources for military needs. On this committee of fifty, the medical profession is represented by a single physician, Dr. Charles A. Dukes of Oakland. At Doctor Dukes' suggestion, the responsibility of making nominations for the twenty district boards of medical referees, each composed of seven specialists (as outlined on page 87 of last month's CALIFORNIA AND WESTERN MEDICINE), was given to the California Medical Association. Thanks are extended to the presidents of the county medical societies who sent in names of physicians such as might be considered for nomination on the composite boards to be appointed for the twenty districts, the territorial areas of which were also outlined in the summary printed in the August issue. The State Adjutant General will make the final recommendations to the Federal authorities.

In Governor Olson's plan, according to press dispatches,* the State would further be subdivided into some 203 registration or examining areas, the civil officials or committee for each of such units to have as one of the members, a physician. At the time of this writing it is not known who is to select the 203 physicians for this particular service, but it is to be hoped that in all such preparations the maintenance of proper cooperation with the Federal authorities, representatives and plans will not be overlooked. The work is altogether too important to be confused by overlapping or working at cross purposes.

* * *

An Unfortunate Proposal: Nonexemption of Medical Students from Selective Service.—For World War I, no professional or vocational group had a better record of efficient service than the medical profession, and in that great struggle, the wisdom of not inducting medical students into active military service was demonstrated. In present day air warfare, with possibilities of casualties to the

civil population in almost limitless numbers, adequate medical personnel for both military and civil needs are indicated more than ever before. Reference need only be made to the recent announcement in the *Journal of the American Medical Association* in which the enlistment of American physicians for civilian service in England was stressed, that request having come through official channels.

Surprising, therefore, are the United Press dispatches from Washington of August 20, in which it is stated:

Starting executive consideration of its version of the measure, the House committee also tentatively approved two other features. One was adoption of the World War exemption for ministers and divinity students. *The other was refusal to provide deferments from service for medical students.*

It is to be hoped that the House Military Affairs Committee will reconsider the proposed nonexemption, since both the public health welfare and that of the military services of the United States would seriously be crippled if such a provision is included in the selective draft law. In an editorial in the *San Francisco Chronicle* on other phases of Selective Service, a statement appears that is particularly pertinent:

There may even be contingencies in which youth can and should be spared so far as possible, not as a matter of special rights but for public policy.

Members of the California Medical Association are requested to follow the course of this proposed legislation. In the meantime, officers of the Association will send informative data to California Congressmen.

COUNCILOR DISTRICT POSTGRADUATE CONFERENCES

Mother Lode Councilor District Sets an Example in Postgraduate Conferences.—To the Mother Lode Councilor District, made up of the following counties: Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Nevada, Placer, Plumas, Sacramento, Shasta, Sierra, Sutter, Tehama, Yolo and Yuba will belong the honor of having been the first of the nine councilor districts of the California Medical Association to have proposed, and carried through to successful conclusion, a postgraduate conference for the members of the component county societies included in its councilor territory. This pioneer spirit is quite in keeping with the past medical record of the Mother Lode region, since the "Sacramento Society for Medical Improvement"—the name given by its founders to what is now the oldest of the component county units of the California Medical Association—made it possible for California, under the leadership of Thomas M. Logan, M. D., to have the honor of creating the second State Board of Public Health in the United States, as well as reestablishing the Medical Society of the State of California.

* * *

Councilor District Organization Worthy of Consideration.—In this issue's postgraduate column appears the program of the Eighth District

* See item from the *San Francisco News* in this issue, under California State Council of Defense, on page 135.

Postgraduate Conference.* Attention of officers of county societies is directed thereto, in the hope that, through similar coöperative effort, councilor conferences may be inaugurated in other districts. In this connection, attention may also be called to the district societies provided for in the by-laws of the American and California Medical Association, but which, in California, by contrast to some of the state medical associations in the Middle West and East, have never been organized.

The value to be derived from district organization is not to be discounted, because, through such contacts, it is possible for many members of the State Association who do not attend its annual sessions to meet colleagues and benefit from the exchange of views on topics related to scientific and organized medicine. Therefore, since postgraduate conferences sponsored by district councilors and committees can present programs analogous to those given at the annual sessions of the California Medical Association, and also afford opportunities for scientific and fraternal exchanges for many physicians who, because of the extensive geographical domain of California, find it difficult to get to the annual State meetings, it would be in order to encourage district postgraduate or refresher conferences.

The California Medical Association Committee on Postgraduate Activities, which may be addressed at the central office of the Association (450 Sutter Street, San Francisco), will, as usual, be glad to furnish all possible aid in any such endeavors.

Query: Which of the other eight councilor areas will be the first to follow the example set by the Mother Lode Eighth Councilor District?

* * *

On Extra- and Intramural Postgraduate Conferences of Other State Associations.—Before leaving this subject, mention may be made again that, in a number of states, the constituent medical associations, in coöperation with the faculties of their respective medical schools, offer what are known as intramural courses, these being given in coördination with extramural courses—a descriptive term used to refer to courses presented in less thickly populated areas. It is interesting to know that the development of the extramural courses has led to an increased attendance by physicians who are in practice in the nonmetropolitan areas at the intramural conferences held in the metropolitan centers.

In California, great opportunities are available for its four medical schools—two in San Francisco and two in Los Angeles—if their faculties would agree to offer, once or twice each year, in their county hospitals—where a wealth of clinical material is available—one- or two-day refresher courses in review or postgraduate work, that would be open to members of the medical profession throughout the State.

Such coöperation could be made of value to physicians practicing in both metropolitan and rural areas, as well as to faculty members who would make such follow-up studies available to colleagues

in practice in all parts of the State. Why should not such a series of courses be seriously considered by our four medical schools?

SCIENTIFIC EXHIBITS AT THE 1941 ANNUAL SESSION OF THE CALIFORNIA MEDICAL ASSOCIATION

Next Annual Session to Be Held at Del Monte, May 5-8, 1941.—In previous issues of the *OFFICIAL JOURNAL*, members of the California Medical Association were reminded that next year's annual session will be held on May 5-8, at Hotel Del Monte, and that it would be desirable that all who contemplated the submittal of titles for papers to be read before the specialty sections should communicate at an early day with the proper section officers.* Mention was made, too, of proposed changes in the hotel arrangements, through which increased facilities for meeting rooms may be available. Also, that it was in order, for all who contemplate attendance at the 1941 session, to write to Hotel Del Monte, at Del Monte, California, and place their reservations on file.

* * *

Scientific Exhibits to Be Prominently Displayed: Coöperation Invited.—Attention is called at this time to tentative plans for a larger scope and display of scientific exhibits, whereby it is hoped to present material, both in quantity and quality, that will measure up to the best standards of such scientific exhibit departments, as given by some of the state medical associations of the East and the American Medical Association.

A cordial invitation to participate is extended, not only to individual members of the California Medical Association, but to organizations such as the California Heart and Tuberculosis Associations, the four Medical Schools, and the Hooper Foundation, and to affiliated professional groups such as Societies and Boards in Dentistry and Pharmacy, and to State departments having bureaus or activities related to the public health.

If coöperation can be secured from agencies such as have been listed, the interest and value of the 1941 annual session of the California Medical Association will be greatly enhanced. Requests for further information will be gladly answered by the Association Secretary, who may be addressed at 450 Sutter Street, San Francisco.

NO COMPULSORY HEALTH INITIATIVE IN 1940

Initiative Petition Has Failed to Materialize. Owing probably to the seriousness of the world's existing turmoil, California's advance guard of social welfare propagandists has seemingly deemed it wise to abate somewhat in its efforts to inflict a compulsory health insurance law upon the State's

* Addresses of section officers are given in each issue of *CALIFORNIA AND WESTERN MEDICINE*, on Advertising page 6. For other information concerning the 1941 annual session, see *CALIFORNIA AND WESTERN MEDICINE*, August, 1940, page 55.

* Program appears on page 136.

citizenry. At any rate, the initiative petition for such a law—threatened in 1939 in the Assembly Halls at Sacramento as certain to have a place on the State election ballot of November, 1940—has not materialized. That does not mean, however, that leaders among the advocates of a compulsory health law have cast their plans aside. Rather, doubtless, for the moment, they are willing to bide their time until political and other conditions better warrant success in the attainment of their objectives. Whether they are earnestly studying the deficiencies in their paper plans is not known; but that there is certainly need for such intensive application by them, if they would more truly understand the cause they have espoused and promoted as a prophylactic and cure for the hardships so often associated with sickness and injury—especially among citizens of lower-bracket income—must be evident to all who have listened to their discussions and claims. Perhaps, if they would continue their studies, laying aside at the same time some of their prejudices and past conclusions, as arrived at by so many on the basis of erroneous premises, they may yet be persuaded to understand that adequate medical service comprehends not only the element of *quantity*, or number of physicians, but the even more important factor, *quality*, or kind of medical service to be rendered.

* * *

Further Study Indicated for Proponents of Compulsory Health Systems.—In spite of the marvelous advances in conservation of health and life—in which the United States leads the world, and let it not be forgotten, advances made under the existing system of medical practice—it still remains true that a host of well-intentioned theorists display an almost hopeless incapacity to properly orient themselves concerning the healing art, and the means through which, in practice, it has attained its excellent results; and also why changes in medical practice procedures advocated in compulsory health system statutes would make worse, rather than improve, any existing deficiencies.

* * *

Causes and Effects Are Confused.—This existence of erroneous thinking by such persons is difficult to understand, since it can so easily be demonstrated that the responsible factors, for whatever inadequate service may exist, are to be found in most instances, not in the set-up of private or public health medical practice as now existing, but rather in the contributory causative agents of disease, such as poverty, vicious habits, hereditary taints or other conditions. If these elements could be eliminated as etiologic factors, the number of citizens, concerning whom it might be stated that their health or lives had been endangered through lack of accessible medical care, would, in most states of the Union, be found to be almost inconsequential. Wherefore, in this interim between active propaganda campaigns for a compulsory health law for California, the advice is given to proponents of such a measure: that they assiduously endeavor better to comprehend the real nature of the problem they seem so anxious to solve.

A DEPARTURE IN DENTAL EDUCATION: HARVARD'S "SCHOOL OF DENTAL MEDICINE"

Doctors of Medicine in Dentistry.—A notable advance in dental education has recently been announced by Harvard University, that institution having decided no longer to conduct its dental department along the lines of other schools of dentistry, but hereafter as a four-year medical course, with a fifth year devoted to technical and mechanical procedures. In short, Harvard University offers, to matriculants in its dental school, a curriculum in which dentistry will be considered as a specialty in medicine rather than as a separate profession. This radical change in dental teaching has been made possible, in part, through an allocation by the Rockefeller Foundation of "\$400,000 as endowment to the School of Dental Medicine of Harvard University, on condition that the University increase endowment of the School by \$2,150,000; \$1,000,000 to be transferred from University funds and \$1,150,000 to be secured elsewhere before October 1, 1941."

The annual report of the Rockefeller Foundation for 1939 states:

In recognition of the present situation in dentistry, Harvard University has drafted a reorganization of its dental school, which will place dentistry on the basis of a specialty of medicine. The Dental School will become the School of Dental Medicine, and graduates of the School of Dental Medicine, after finishing the same preclinical courses and much of the same clinical work given the medical students, will be entitled to the degree of Doctor of Dental Medicine.

* * *

Reasons for the Change.—The Rockefeller statement also presents the following pungent thoughts, with which many physicians will agree:

Most students of dental education believe that a shift from emphasis upon mechanical ingenuity to emphasis upon the biological sciences underlying medicine itself, but equally applicable to dentistry, would form the wisest course for the improvement in dental education. The dentist stands to gain from a wider knowledge of medicine—and he knows it. The physician would profit from a better knowledge of the factors underlying the anatomy, physiology, and pathology of the oral cavity—whether he knows it or not. The time has arrived for some active and intelligent team play between a well-supported school of dentistry and a school of medicine.

It will be interesting, therefore, to observe how this new plan of dental education and training will be received by dental schools in the United States and also to note as the years go by the influence of this experiment upon American medical and dental schools.

ON VARIOUS TOPICS

Disease Outbreaks Resulting from Faulty Environmental Sanitation.—It may be of interest to some physicians to learn that not until last year did the United States Public Health Service authorize "a nation-wide survey of outbreaks of disease caused by faulty sanitation in general."

In an interesting article, appearing in *Public Health Reports*, Vol. 55, No. 31, August 2, 1940, Leslie C. Frank, Senior Sanitary Engineer, U. S. P. H. S., calls attention to the fact that the reports

on food, water and similar outbreaks received from different states are far from complete, not only as to the number occurring in different commonwealths, but also as to the epidemiologic backgrounds of the outbreaks. Further, that in some instances, where proper studies have been made, State officials have failed to send to Washington copies of the reports of their findings.

For instance, as regards outbreaks due to milk and milk products, it is stated that:

New York State, California, and Minnesota combined reported nearly as many milk-borne outbreaks as all the rest of the country combined, although these three states represent only about one-sixth of our entire population.

Frank concludes his article with the following significant comments:

All in all it seems safe to estimate that there are probably 5 to 10 or more times as many outbreaks, cases, and deaths resulting from faulty sanitation as are herein reported for 1938. Such an estimate would then represent 1,000 or more deaths per year resulting from faulty sanitation. That this is a conservative estimate is evidenced from the fact that during the past five years the total number of cases of typhoid fever alone occurring in the United States has been from 12,000 to 18,000 per year, and the fact that most typhoid fever cases are probably the result directly or indirectly of some breakdown in environmental sanitation.

Finally, it should be noted that the above discussion takes no account of the fact that typhus fever, with 2,300 cases and 137 deaths in 1938; undulant fever, with at least 2,000 to 3,000 cases per year; and malaria, with several hundred thousand cases and several thousand deaths per year, are all the result of faulty environmental sanitation.

* * *

"Quarterly Journal of Studies on Alcohol."—With governments, the consumption of alcohol by citizens always means the creation of social and other problems. In the United States, the attempt to do away with the evils of alcohol, through prohibition, only made matters worse. However, since the repeal of that federal law, some of the evils associated with the use of alcohol as a beverage have not greatly abated.

To meet a need for accurate study of the alcohol problem, with special relation to its medical phases, a new publication has appeared, the *Quarterly Journal of Studies on Alcohol*, with Howard W. Haggard, M. D., as editor, and brought off the press in New Haven, Connecticut. Volume I, Number 1, contains among its articles: "Personality Factors in Alcoholic Addiction"; "The Influence of Alcohol on the Digestive Tract"; "The Effects of Alcohol on the Normal and Pathologic Kidney"; and "Effects of Alcohol on the Individual."

Physicians who are interested in the subject should obtain copies of this recent addition to medical publications.

* * *

Michigan's Physicians and the State Governor.—The medical profession in States of the Union other than California also have their legislative trials and tribulations. A recent issue of the *Journal of the Michigan State Medical Society* played up with brief, biting comment, in wide display spacing, a list of experiences with the gubernatorial powers in the Wolverine State. For whatever consolation may be derived therefrom, and also to bring out the fact that the physicians of

Michigan do not hesitate to state their case in print, the list of charges is here given:

HERE'S WHAT THEY DID TO YOU [TO PHYSICIANS IN MICHIGAN]

July, 1939

The Crippled Children's Commission cut 33 per cent from Schedule A (without consultation with the medical profession).

October, 1939

Schedule A was restored by the Crippled Children's Commission (without consultation with the Administration).

November, 1939

You were accused of being hi-jackers by a spokesman for the Administration.

December, 1939

You were told to take it and like it (by the legal advisor to Governor Dickinson).

March, 1940

A decrease of 40 per cent was ordered by the Administration in spite of your protests.

Now

What are you going to do on September 10 at the Primaries?

And on November 5 at the Election?

* * *

Ophthalmological Facts, Fads and Fallacies.

The July number of the *United States Naval Bulletin* prints an article from the pen of R. C. Boyden, M. D., Lieutenant, Medical Corps, U. S. N., having as its opening sentence:

Too many *synthetic ocular symptoms* are accepted by the medical profession without scientific investigation. . . .

In a paragraph that follows, the author goes on to say:

The following observations are the result of the writer's findings and opinions only. It has been noted that, in the Navy, the number and variety of complaints of an ocular nature have been on the increase in the past several years. This may be due to any one or combinations of the following factors:

1. Misinformation circulated by retailers of glasses whose profits vary from 3 to 22 dollars on each sale, and health articles pertaining to ocular symptoms due to so-called eye-strain.
2. Exaggerated belief in the value of glasses for the relief of symptoms.
3. Neurotic fixation or inadequate personality.
4. Definite malinger and desire to excite sympathy.
5. Reluctance to make cruises because of family or other ties ashore.

Discussing the complaints made by the sailors, Lieutenant Boyden refers to a number of such as "synthetic symptoms," making the following comments:

The term *synthetic symptoms* has been used to characterize the complaints voiced by patients in which no pathology can be demonstrated. The examinations used to rule out pathology were complete and included all of those well known to those doing ophthalmological work. The symptoms most frequently encountered were:

1. Headache: (a) Usually bitemporal, and cast in the same mould with the headaches of neurosis or hysteria.
2. Burning sensation in the eyes: Following periods of reading or movies.
3. Blurring of vision: Following short periods of reading or study.
4. Poor vision: Usually unilateral.
5. Sensitivity to light.
6. Postorbital pain.
7. "Pulling sensation."
8. Muscular twitching of lids.
9. Diplopia.

10. Astigmatism: A popular expression among the laity and occasioning a garrulous recital of previous examinations and opinions of unscientific advisors.

11. "Eye-strain": A general symptom complex embracing any one of several of the above symptoms.

12. Blindness: (a) Unilateral or bilateral. (b) Sudden onset.

Among the reasons for his article, the author lists:

1. The increasing frequency with which young healthy men recently accepted in the naval service with normal vision are appearing in naval ophthalmological clinics with synthetic symptoms and routine requests for refraction.

2. The incessant drain on the medical officer's time, averaging 1 hour and 15 minutes per patient, in ruling out possible pathology in these individuals, and the resultant loss of time available for examination and treatment of those who present themselves with genuine symptoms based on organic lesions.

The above quotations are given because they may be worthy of consideration by physicians in private practice, especially by practitioners who consciously or unconsciously refer patients to optometrists instead of to doctors of medicine who are eye specialists.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 132.

EDITORIAL COMMENT†

GELATIN AND PHYSICAL ENDURANCE

The public is at present subjected to a barrage of advertised claims, the alleged strength-producing or fatigue-reducing effects of gelatin as a supplementary food. According to Doctor Hellebrandt¹ and his coworkers of the Department of Physiology, University of Wisconsin, these claims are at present unwarranted, based on misinterpretations of inadequately controlled gymnasium tests.

That glycine is an amino-acid capable of increasing the creatine content of skeletal muscle is an established fact, the basis for proposed methods of treatment of certain myopathies. Gelatin contains 25 per cent glycine. About a year ago Ray, Johnson and Taylor,² of Long Island College of Medicine, attempted to apply gelatin therapy to normal individuals. Selected athletes on habitual diets were given a daily endurance test on a bicycle ergometer and afterward retested on the same diet plus 45 to 60 grams daily intake of commercial gelatin. The Brooklyn physiologists noted a gradual increase in the daily maximum energy output on this supplementary diet, the recorded

muscular work being increased about 100 per cent by the fortieth day. Supplementary gelatin feeding was then discontinued. A 33⅓ per cent fall in maximum energy output was noted by the 110th day. Assuming that the supplementary gelatin is the only variable in these tests, the Brooklyn physiologists concluded that the glycine fraction of gelatin is a specific food, increasing muscular endurance and, therefore, decreasing muscular fatigue.

Doctor Hellebrandt and his coworkers call attention to the fact that gelatin is not the only variable in such endurance tests. The protein content of habitual diet, psychical factors, training effects, and athletic "staleness" must also be taken into account. In the hands of the Wisconsin investigators, athletes maintained on their habitual diets increase their maximum daily endurance fully 100 per cent by the end of sixty days solely as a result of training. Gelatin added to the habitual diet during this period neither increases nor decreases the rate of athletic improvement. Moreover, "staleness" effects began to be apparent after the sixtieth day of maximum daily work, a 15 per cent reduction in maximum endurance being recorded by the one hundredth day. Gelatin added to the habitual diet during this period neither prevents nor hastens the rate of development of this "staleness." If the Wisconsin data are confirmed, the alleged fatigue-reducing effects of gelatin are illusory, a misinterpretation of effects observed on fortuitous additions or withdrawals of gelatin at critical periods during athletic training.

Gelatin, of course, has a legitimate place in dietetics. Many habitual diets are deficient in protein, and might conceivably be improved by the addition of gelatin. Gelatin, however, is an "incomplete" protein, being deficient in certain essential amino-acids. Control tests of the possible fatigue-reducing effects of other proteins are now in progress in two eastern medical schools. Clinical judgment, therefore, should be reserved till the promised statistical evidence is available.

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W. H. MANWARING,
Stanford University.

A SIMPLE TEST FOR LATENT JAUNDICE*

With the advent of vitamin K and a quickening of our interest in the bleeding tendency accompanying the jaundiced state, a short, simply performed test for the detection of latent jaundice is of considerable importance to the medical profession.

Latent jaundice may be defined as that state of icterus existing when the bile pigments circulating in the blood are at a level above normal, and yet are not in high enough concentration to tinge the mucous membranes, skin or sclerae with the characteristic yellow color. Expressed in terms of the icterus index, it may be defined as that reading above 10 and below 20.

In other words, there is, in the patient who is developing jaundice, an interval during which the bile pigments, although increased, are not discernible

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Hellebrandt, F. A., Rork, Rozell, and Brogan, Elizabeth: Proc. Soc. Exp. Biol. and Med., 43:629 (April), 1940.

² Ray, G. B., Johnson, J. R., and Taylor, M. M.: Ibid., 40:157 (Feb.), 1939.

* From the Department of Surgery, University of California Medical School.

ble clinically. This is an important period. We may suspect oncoming jaundice from the clinical history, and usually corroborate it with the laboratory procedure known as the icterus index test. This requires time and demands the use of a colorimeter.

The test to which I wish to call attention is instantaneous, accurate, and calls only for equipment usually found in the physician's office. Description of it first appeared in the German literature ten years ago, but was promptly forgotten. The test consists of the intracutaneous injection of 0.10 cubic centimeters of 1 to 1000 solution of histamin in the form of a wheal on the flexor surface of the forearm. In the normal patient with an icterus index below 10, this wheal will remain colorless. In the patient with latent or actual jaundice, it will rapidly become yellow. The test is accurate, and its only contraindication lies in the possibility of its being given to patients who may be sensitive to histamin. The small dosage and low dilution, however, should preclude serious reactions.

This is a valuable procedure, and one that will be of considerable import in judging prognosis, formulating diagnosis, and advising appropriate treatment of the patient with early, subicteric jaundice.

490 Post Street.

HAROLD H. LINDNER,
San Francisco.

Fan in Bedroom Need Not Endanger the Health If Properly Used.—An electric fan in the bedroom need not endanger the health if proper attention is given to the type of machine and its location, W. E. Carson, M. D., Pittsburgh, advises in *Hygeia, The Health Magazine*.

For comfort on hot nights without fear of inducing colds, neuritis or rheumatic symptoms, Doctor Carson points out, the fan should not blow directly on the occupants of the room. It should not produce a noticeable breeze but rather a gentle, continuous circular current of air around the room. "The ideal arrangement for a small or medium sized room," he says, "is to have the fan on the wall slightly above the heads of the occupants, so placed that the air current will be directed at an angle to cause it to impinge successively on the different walls in the room. For larger rooms, two fans may be used."

Other satisfactory positions for the fan are on a table near the bed and on the floor at the side of the bed. In both instances the fan should be turned to blow away from the bed.

"A fan giving a direct or continuous air current is to be preferred to the oscillating type," Doctor Carson recommends. "It is self-evident that a fan does not cool the air but acts to give comfort only by preventing the accumulation of a stagnant or dead layer of air around the individual. For this purpose a gentle continuous current of air is more effective than the intermittent puffs of an oscillating fan. Moreover, the former type is less expensive than the oscillating type, is simpler in construction and is more easily kept in working order. The oscillating fan is preferable only when it is desired to keep flies or other insects from lighting on foodstuffs."

Efforts to eradicate tuberculosis should not be spread thin like butter over bread.—Louis I. Dublin, M. D., Metropolitan Life Insurance Company.

ORIGINAL ARTICLES

THE INTERPRETATION OF LABORATORY EXAMINATIONS IN THE DIAGNOSIS OF INFECTIOUS DISEASES*

By CHESTER S. KEEFER, M. D.
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PART I

IN the diagnosis of infectious diseases, the physician relies mainly upon the clinical features and the course of the disease, together with the laboratory examinations. Indeed, there is no field of medicine in which the correct interpretation of laboratory examinations yields greater information than in the infectious diseases. Every few years new diagnostic tests are recommended and, in order that we may obtain the maximum assistance and at the same time appreciate the limitations of such tests, it is well to review in a critical manner a number in common use. Today I propose summarizing some of the practical interpretations of laboratory methods, when applied to the diagnosis of infectious diseases, as illustrated by cases which have come under my own observation.

THE SIGNIFICANCE OF BACTEREMIA

A very common problem in medical diagnosis is the determination of the cause of fever without localizing signs. A frequent examination in this situation is to culture the blood for organisms. The cultures should be incubated in an atmosphere of 10 per cent CO₂, as well as aerobically, since in this way some organisms will grow which would fail to do so if only one method were used. This is particularly true of *Br. abortus*, the gonococcus and meningococcus. The common contaminating organisms, in our experience, are staphylococci and diphtheroids; less often colon bacilli and nonhemolytic streptococci. When staphylococci, colon bacilli, or nonhemolytic streptococci are found in the circulating blood, their significance must be interpreted in the light of the clinical picture and the nature of the primary infection. The presence of micro-organisms in the blood is diagnostic for certain infections, but in others it yields information that is of greater significance in prognosis. This is especially true in pneumococcal, streptococcal and staphylococcus infections, in which the fatality rate without special forms of treatment is between 70 and 98 per cent. For this reason it is of great importance to culture the blood in all cases of these infections, in order that information of prognostic value may be obtained.

Speaking broadly, bacteremia is due to a temporary loss of equilibrium between the normal clearing mechanism of the blood and tissues, and the local defense mechanism at the site of the primary infection, or it may mean that there is an intravascular focus of infection, such as a thrombophlebitis or

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endocarditis. The interpretation of bacteremia must depend upon the circumstances in which it is observed.

A few diagnostic points in the interpretation of blood cultures may be outlined as follows:

The presence of bacteremia in a patient with mastoiditis should immediately raise the question of a complicating lateral sinus thrombosis, just as bacteremia following tonsillitis suggests thrombophlebitis of the tonsillar veins.

The finding of colon bacilli in the blood, in an individual with pyelonephritis who has not been cystoscoped, catheterized or operated on, should suggest thrombophlebitis of the renal or interlobular veins of the kidney. Colon bacillus bacteremia without signs of pyelonephritis usually means an infection of the gall-bladder or biliary passages.

Staphylococcus aureus bacteremia, without localizing signs of infection, usually indicates an infective endocarditis or an osteomyelitis which has failed to produce localized symptoms. Occasionally—and this is true in about 10 per cent of the cases—there is no obvious portal of entry, and the course is so rapid that no focal abscesses are ever found. Other local foci of infection may be found in the prostate or the muscles.

Pneumococcus bacteremia without pneumonia suggests (1) osteomyelitis, especially in children; (2) paranasal sinus disease; (3) pneumococcus infection of the peritoneum or biliary passages, especially in patients with cirrhosis of the liver, or lipid nephrosis, and (4) pneumococcus endocarditis.

Hemolytic streptococcal bacteremia, without obvious local signs of infection, should suggest thrombophlebitis of the pelvic veins, the tonsillar veins or the veins of the skull; rarely thrombophlebitis of the axillary or pulmonary veins. Following pneumococcus pneumonia, hemolytic streptococcal infection with bacteremia may be observed. It indicates a superinfection of the lung or an infection of the middle ear and mastoid cells. In rare cases it may be a sign of a peritonitis.

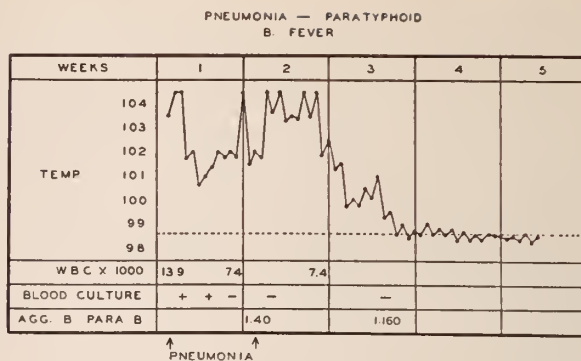
It is generally assumed that the presence of typhoid or paratyphoid bacilli in the blood is sufficient for the diagnosis of enteric fever, in the sense that the primary focus is in the gastro-intestinal tract. On occasions, however, it may indicate that one is dealing with a focus of infection elsewhere which is responsible for the bacteremia, and the recognition of such a focus may assist in treatment. As a rule, such foci of infection are found in the gall-bladder, the spleen or the kidneys.

The following cases illustrate the importance of blood cultures in the diagnosis of infections as well as the difficulty in their interpretation.

REPORT OF CASES

A young man with high fever, leukocytosis, and pneumonia shows pneumococcus Type XVIII and B. paratyphosus B in the sputum, and B. paratyphosus B in the blood. His clinical course was that of pneumonia and enteric fever.

CASE 1.—A young man, 18 years of age, entered the hospital complaining of sharp pain in the chest of one day's duration. He was well until five days before admission



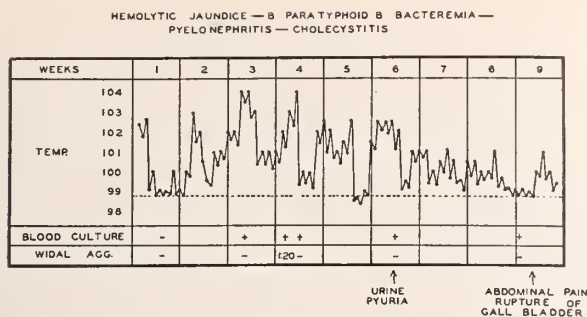


Fig. 2.—(Case 2) Chart showing temperature curve and bacteriologic and serological findings in a patient with hemolytic jaundice and *B. paratyphoid B* bacteremia.

globin 45 per cent, and white blood cell count 5,280. Icteric index was 15 units, bleeding and clotting times were normal, and the reticulocyte count on the day of admission was 0.6 per cent. The stools contained bile pigment. A fragility test showed increased fragility of the red cells characteristic of hemolytic jaundice. The urine was negative except for the presence of a moderately increased amount of urobilinogen. Blood cultures, taken on the third day of entry, were negative. Fig. 2 shows the course of the temperature curve during a period of nine weeks, together with the results of the blood cultures and certain features which appeared during the course of illness.

From the beginning of the third week of illness until the man's death, the blood contained paratyphoid B bacilli on a number of occasions. At the beginning of the sixth week his urine became cloudy and contained numerous leukocytes; and *B. paratyphosus B* was isolated on culture. Several days before death the patient was seized with an acute attack of pain in the upper part of the abdomen, followed by increased rigidity and muscle spasm. He failed rapidly and died nine weeks after admission to the hospital.

The stool cultures were constantly negative for any organisms of the typhoid dysentery group. Widal reaction was carried out, using strains of typhoid bacilli, paratyphoid A and paratyphoid B. On one occasion, two weeks after admission, the Widal was positive, using paratyphoid A, 1:20; but there was no agglutination for paratyphoid B or typhoid bacilli, and no agglutinins appeared in the circulating blood during the entire course of his illness.

The necropsy showed an acute cholecystitis with perforation and generalized peritonitis, splenomegalia with sterile and infected infarcts, multiple abscesses of the kidneys, and jaundice. There were no signs whatsoever of ulceration of the intestines.

From the course of events and the necropsy findings, it would appear that we were dealing with a patient who had hemolytic jaundice and *B. Paratyphosus B* sepsis. The original focus of infection for the bacteremia was not in the gastro-intestinal tract, as might be supposed from finding paratyphoid bacilli in the circulating blood, but they probably arose from the spleen or gall-bladder, and subsequently produced a pyelonephritis. Typhoid or paratyphoid bacilli are found in the circulating blood in the absence of enteric fever when there are foci of infection in other organs, such as the gall-bladder, spleen, or the kidneys; rarely the lungs, bones, or other organs. Many of these infections have been recognized within the past few years as being caused by *B. suipestifer* or paratyphosus C. An excellent review of *B. suipestifer* infection was made recently by Harvey.⁴ Infections of the spleen with this group of organisms had been recorded by Meleney⁵ and Walker and Weiss,⁶ those of the kidney by Morgan,⁷ and those of the gall-bladder by Schottmuller⁸ and others. One interesting feature that stands out in many of these infections,

due to the paratyphoid-suipestifer group, is that they often show up and occur, as in the present case, when there is some chronic illness. Indeed, they occasionally occur as a terminal infection in the course of a disease such as miliary tuberculosis.⁹

The following case illustrates how the positive blood culture gives one an indication concerning the etiology of the underlying infection, in spite of the fact that one may not be able to find decisive evidence for the primary infection.

A man develops chills and fever without localizing signs. Staphylococcus aureus cultured from the blood. Patient dies within seven days after onset, with bilateral bronchopneumonia and acute vegetative endocarditis.

CASE 3.—A man, 52 years of age, was perfectly well until five days before admission to the hospital when he was suddenly seized with a chill and fever and sharp, stabbing pain in the region of the right hip joint. One day later he had another chill with fever, dry unproductive cough, marked prostration, and malaise. His symptoms of prostration increased very markedly within the next few days. Nausea and vomiting became troublesome, as did shortness of breath at rest. His previous histories were non-contributory.

Physical examination showed an acutely ill man who had marked dyspnea. The skin and mucous membranes were dry and showed slight jaundice. Respirations were rapid and shallow and there were numerous, fine, crackling râles at both bases posteriorly. The heart was normal in size and the sounds were clear. There were no murmurs present. The abdomen was negative except for slight tenderness in the costovertebral angle. The extremities were negative. Temperature was 103.6 degrees Fahrenheit, pulse rate 85, and respiratory rate 32. Examination of the urine showed a small amount of albumin, an increase in the number of red cells, a few leukocytes, and an occasional hyaline and granular cast. The red blood cell count was 4,380,000, hemoglobin 85 per cent, and white blood cell count 8,700. X-ray of the chest revealed a diffuse mottling of the lower two-thirds of the right chest and left base. A diagnosis of bronchopneumonia was made. Blood culture on the day of admission showed numerous colonies of *staphylococcus aureus*.

The course of his illness in the hospital was one of progressive failure. The signs of pneumonia increased, blood cultures were positive daily, and on the seventh day of his illness he developed all the signs of peripheral vasomotor collapse, had auricular fibrillation, and died.

The course of this patient's illness, which was extremely rapid, was due to *Staphylococcus aureus* sepsis with bronchopneumonia. The precise diagnosis was not made until the blood cultures were taken. The necropsy showed, in addition to the bronchopneumonia, an acute vegetative endocarditis due to the *Staphylococcus aureus*. In about 10 to 15 per cent of all cases of *Staphylococcus aureus* bacteremia it is not possible to find a focus of entry, and the only way in which a diagnosis can be established is by means of blood cultures. The acute vegetative endocarditis was a finding that was totally unsuspected clinically; but it is in these cases that one not infrequently finds the early stages of bacterial endocarditis due to the *Staphylococcus aureus*.

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(To be continued)

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THE MIDDLE ROAD IN OBSTETRICS AND GYNECOLOGY*

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EVERY now and then it is well for us to pause and reflect upon current trends in medical practice, and upon how we, as individuals, fit into the picture. We, in the field as it were, cannot all be originators of great ideas or procedures, but we may try to be discriminating as to which can be adapted to our own capabilities and temperaments. Fundamental trends in medicine, however, are the products of innumerable minds; we should, therefore, it seems to me, attempt broadly to agree with these until adequate scientific reasons appear for us to do otherwise. But it will always be our problem and duty to conscientiously attempt to distinguish between mere fads and real advance, the while avoiding that overcaution which can stifle progress.

The last several decades have seen a gradual trend toward less surgical and more medical treatment in obstetrics and gynecology. A great fund of endocrine knowledge and theory is accumulating, and manufacturers of endocrines can now supply potent extracts for substitution therapy. Doubtful products of the type offered not so long ago, which were aptly referred to by someone as "slaughterhouse refuse," are disappearing from the market as the demand for properly assayed material increases.

TREND TOWARD CONSERVATISM

The pendulum has been swinging toward a moderate conservatism in gynecologic circles, but there remain a number of men both in and out of the specialty who must be classified as "radical" in their approach to their daily problems. On the other hand, I have seen the work and read publications of others who, in my opinion, are practically hide-bound in their medical outlook. A doctor of this type, in obstetrics particularly, may be blithely following the teachings of the nineteenth century masters of the art, designed as a way out of difficulty in the exigencies of farmhouse practice, in his procedure at the modern, well-equipped maternity.

* Chairman's address, read before the Section on Obstetrics and Gynecology, at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.

Thus the ultraconservative obstetrician becomes, as a matter of fact, the radical, with too frequent unhappy results. Induction of labor at term in normal pregnancy offers a case in point. This procedure has been decried in some quarters as unnecessarily radical, particularly if artificial rupture of membranes is included. In a good hospital, under modern aseptic conditions, with vertex presentation, an adequate pelvis and the cervical canal effaced, I can see no valid objection to its fairly frequent use. Far better, at times, I believe, is this than the head-long rush of the multipara in active labor to the hospital in the family car driven by the distracted husband. Mathieu and Holman have reported a fairly large series of cases with no significant increase in morbidity or mortality of either mother or child. I do not recommend routine employment of induction of labor, but he who categorically condemns it is not making the most of the obstetric art. I feel much the same way about the use of so-called "prophylactic" outlet forceps. Whether or not there is anything prophylactic about it, a woman is frequently saved a lot of work; and if the proper type of forceps is skillfully and gently used, merely to reinforce each labor pain after the head reaches the perineum, no harm, I am convinced, will result. There might even be a lower incidence of extension of the episiotomy wound due to better control.

GYNECOLOGIC ENDOCRINOLOGY

Let us glance again at the subject of gynecologic endocrinology. Here is a great new vista gradually appearing before our eyes, but much, here and there, cannot yet be seen. Work conducted by competent investigators is constantly going on in university laboratories; each year brings new discoveries; but I venture to say that the surface of the subject has as yet only been scratched. The whole story will probably never be known, for therein seems to lie the riddle of life itself, the solution of which Nature will no doubt always contrive to withhold from us. Osler reminded us that, "In seeking absolute truth, we aim at the unattainable and must be content at finding broken portions." This is not the defeatist attitude that it appears to be. One can always strive to apply the knowledge already available in a rational manner. We who are practicing our profession at the bedside and in the office should leave the endocrine experimentation to those who are qualified to conduct it. The indications for the use of almost any endocrine product from whatever manufacturer, as stated in their advertising leaflets, cover practically all of the functional derangements in gynecology. They are fond of parading before us the results of endocrine therapy in rodents and monkeys. No doubt these statements usually agree with the facts, but what is left unsaid is often of more importance to the practitioner. The effect of these products in human beings is often something else again, or they may even be to all intents and purposes inert. The patient who pays high prices for endocrines is entitled to their rational and discriminate use on the part of her doctor, who gains his information on the subject from his well-considered experience and the writings of competent laboratory and clinical observers in the recent medi-

cal literature. Treatment by trial and error may be justified in the occasional case, but it is not best for the patient's health or the doctor's soul if it is made the rule. Then, again, there is a more important and often tragic angle to the subject. Every gynecologist has seen valuable time lost in undiagnosed cases of cancer, ectopic pregnancy, bleeding submucous fibroids and the like, which have had unsuccessful attempts at hormone therapy. Gynecologists appear in agreement that most cases of metrorrhagia before the menopause, and any bleeding thereafter, should have thorough curettage for microscopic diagnosis, unless contraindications exist or the cause of the bleeding be readily apparent.

WHY THERAPEUTIC METHODS DIFFER

In every sizable city are well-trained colleagues who differ among themselves as to the proper handling of various conditions. This cannot in any sense of the word be considered a state of mental confusion or a lack of appreciation of the fundamentals involved. In general, it bespeaks a difference of method or of approach to a problem based usually on the divers temperaments of the men themselves. Early professional training also plays a large part. It does not mean that one man must necessarily be wrong and the other right, even when considering a given case. Unlike the comings and goings of the planets in the heavens, there is nothing exact or always predictable about medical science. No mathematical formula being available by which to reduce each separate problem to its simplest terms, we should consider it a privilege to weigh the opinions of others, however divergent their views may be, provided they have the training and outlook necessary to engender our respect. Henry James condemned that peculiar type of blindness which prevents our seeing things from the viewpoint of others. In our approach to a problem let us not always follow the same groove. Let us regard each patient as an individual, and give due consideration, as far as circumstances will permit, to the methods used by our respected colleagues.

PLACENTA PRAEVIA

Consider, for instance, the subject of placenta praevia. Leaving out of this discussion the barbarous and now universally discredited practice of accouchement force, think of the many procedures available that can be used on occasion to treat it. Unfortunately there are those who recommend a standard treatment in almost all cases; and whether this is routine cesarean section or only rupture of the membranes, they can quote statistics to prove their point. How much more rational it would be for us, according to my feeling, to weigh the opinions of all; to handle each case individually, making good use of experience and judgment as to what course to follow. Temperament, training and the facilities at hand must influence the decision, but the conditions found in the patient should be the major factor. The amount of bleeding, the state of the patient, parity, condition of the baby, condition of the cervix and the quality of contractions, among others, should determine the procedure in the individual case. I am convinced that such a

course, making use at one time or another of all accepted ideas, will in the long run give the best results. Only by thus avoiding both the too radical and the ultraconservative as a routine, can we attain this goal.

VITAMIN THERAPY

Within our adult memory there have appeared, or rather we have become aware of the various vitamins—elusive chemical compounds which have always been with us in Nature, but whose existence, structure and actions have been until recently unknown. It was discovered a long time ago that cod-liver oil would prevent or arrest rickets, and that lime juice would keep the British Navy free of scurvy, but it has remained for our time to find out why. Much valuable research is constantly going on, and many etiologic puzzles have been solved in the vitamin laboratory. Like a fungus, however, the pseudo-scientific aspect of the subject grows at an appalling rate among the laity, and, I hate to admit, has perhaps been unwittingly fostered by the medical profession. It is only human nature for commercial interests to rush to take advantage of the situation by offering vitamin-fortified products, often of doubtful efficacy, all the way from prepared foods to cosmetics and soap. Such antics are probably quite harmless as a rule, but the prescription by the profession of excess amounts of these compounds in pure form may be another matter. Let us always pause to reflect that vitamins are extremely potent substances, and that indiscriminate and long-continued alphabet therapy in amounts never found in nature may show future effects we may have cause to regret. Suspiciously foreboding reports are already beginning to appear in the medical literature. Again, may I urge full use be made of these invaluable drugs, but only in rational amounts and when indicated. The grocery store would appear to be the best and cheapest place for the public to get them for every day use.

ACUTE PELVIC INFLAMMATORY DISEASE

There is one outstanding field in gynecology in which true conservatism is a *sine qua non* to good practice. I refer to acute pelvic inflammatory disease. I am aware of no gynecologist who does not strive to discourage laparotomy in such cases. Sufficient reasons for this attitude are not hard to find. Perforation of an undisturbed pyosalpinx, causing general peritonitis and death, is almost a curiosity, while such an outcome is not uncommon if the abdomen is opened. Furthermore, a fair percentage of cases will, if treated nonsurgically, in time, recover sufficiently to regain the function of the pelvic organs. Some of the milder acute cases are destined to early and, to all intents and purposes, complete recovery. During the first few hours or days one cannot tell which cases will react in this manner. What a tragedy, therefore, to deprive these usually young patients of any chance whatever to have children of their own. If, unfortunately, things do not turn out so favorably, and a pelvic abscess supervenes, drainage can usually be satisfactorily accomplished with a minimum of risk by colpotomy. The acute abdomen is not always a surgical abdomen. Because an inflamed appendix, tense with pus, must

be removed without delay, it does not follow that it is surgical apostasy to leave a fallopian tube in similar condition alone, when the accumulated experience of many years the world over has proved it to be the wiser course. The maxim "*primum non nocere*" has no greater application than in acute salpingitis.

CESAREAN SECTION

Much has been written about cesarean section—its value, indications, technique and its abuses. In regard to the latter, no subject seems to provoke more discussion in obstetric circles. Without assuming an illiberal state of mind, it must be stated that there is good reason for disapproval of the high percentage of cesareans being performed in many hospitals. We have not as yet been able to avoid the fact that this operation carries within itself a certain inescapable mortality; and, just as surely as night follows day, this must catch up with the operator sooner or later. Just as in all obstetrical procedures there are certain definite and other less well-defined indications for its performance, the sanctity of which should not be violated. The whim of the patient, in her lack of information on the subject, is not one of them. The obstetrical problem in the greater number of cases has merely begun at the time of the cesarean section: "Once a cesarean, always a cesarean," unless the informed patient elects to assume the danger lurking in a subsequent delivery through the natural passage.

Some hospitals have made it a rule that no cesarean may be performed without consultation. This has resulted in distinct reduction in the incidence of this operation, with no dire results to anyone concerned. Whether or not the universal application of this requirement would be wise or proper is open to argument, but the fact remains that some hospital staffs have resorted to it in desperation.

On the other hand some men go to the opposite extreme: there must be a formidable set of ironclad indications present before they resort to section with fear and trepidation. We have all read reports literally glowing with pride, detailing the protocols of hapless patients who, after horrendous and protracted labors and deliveries, had escaped cesarean section. It cannot be gainsaid that such reports can often show low maternal mortality statistics; but, in my opinion, while admittedly the most important, a low mortality is not the whole story. There are, after all, such things as badly torn cervixes, third-degree lacerations of the perineum, increased incidence of puerperal infection and various tragic injuries to, or loss of the child which have to be taken into account. In obstetrics, there is little to choose, in my way of thinking, between that attitude which has been aptly termed "paraplegia pollyanna" and a surgical jamboree.

IN CONCLUSION

Every man who tries to practice medicine conscientiously can think of numerous other situations where the tug of war goes on between those whose approach to a given problem seems either too radical or too conservative. Each have factors in their favor at one time or another; neither is ever always

right. In all cases, however, it is the patient who takes the risk. How much better, it seems to me, to try to strike a balance somewhere between radicalism and conservatism in outlook and in action; to keep an open mind, not overenthusiastic about unproven novelties, nor yet closed to progress; to avoid undue haste without becoming mired in the muck of indecision. It is my conviction that the ends of our art will best be attained if we take the middle road.

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PNEUMONIA IN CHILDREN: TREATMENT WITH SULFAPYRIDINE*

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THIS study represents observations made on 126 cases of pneumonia in children all under fourteen years of age treated with sulfapyridine. They were observed at the Los Angeles County General Hospital from March through December of 1939. During this period there were fewer cases of pneumonia in children and the degree of severity of the disease was less as compared with former years. This fact may have had some effect on our mortality rate.

Ninety-nine of the cases included in this series were diagnosed as lobar pneumonia and twenty-seven as bronchopneumonia. Six cases, all in children under two years of age, were secondary to measles. The cases here presented comprise approximately half the total number of pneumonias seen during the period of observation. Those selected were the most toxic and some specific therapy seemed indicated. No other method of therapy was employed except those measures which were indicated for the comfort of the patient. In order to maintain uniformity in the clinical observations, all cases of pneumonia in children seen in the hospital during this period were under the direct control of the authors who were ably assisted by the interns on the service. Each patient was examined and observed by at least two of this group each day.

DIAGNOSTIC PROCEDURE

Before starting therapy on any case, the following criteria were fulfilled: (1) clinical diagnosis of severe, toxic pneumonia; (2) confirmation of the physical diagnosis by x-ray; (3) a complete blood count; (4) a urinalysis; (5) a blood culture; and (6) sputum typing. For the latter, material was obtained by swabbing the nasopharynx and larynx. If no type was obtained, this procedure was repeated three to five times. Failure to obtain a type did not defer treatment if the other criteria had been fulfilled.

DRUG DOSAGE

The twenty-four hour dosage was calculated on the basis of 1 to 1.5 grains per pound of body weight. This daily dose did not exceed 90 grains in

* Read before the Section on Pediatrics at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.

TABLE 1.—Age Distribution

Age in Years	Number	Per Cent
0-1	29	23
1-2	30	24
2-4	21	17
4-8	23	18
8-14	23	18
Total	126	100

any twenty-four-hour period. The total daily dose was divided by six and given at four-hour intervals day and night. The initial amount of sulfapyridine given was double the calculated four-hour dose. The drug was given orally in all but seven cases. In the latter sulfapyridine was given per rectum. Milk was the usual vehicle. Sodium bicarbonate was not given routinely with the drug.

FOLLOW-UP PROCEDURES

The routine follow-up was: (1) daily chest examination; (2) complete blood count every twenty-four to forty-eight hours during the time of drug administration and every three days thereafter as long as the patient remained in the hospital; (3) urinalysis every three or four days; (4) x-ray taken one week after the temperature reached normal if the lungs were clinically clear, with subsequent ones as indicated, and (5) sulfapyridine blood concentration determination daily, continued one to two days after the drug was stopped. Blood for this determination was taken each morning at the same hour on all the patients.

AGES

In this study we were most concerned with the effects of this new drug on the young child suffering with pneumonia. Lobar pneumonia in children over four years of age is as a rule not seriously hazardous to life. Death rates rarely exceed 8 per cent. But that group of children under four years of age suffering with pneumonia, especially of the primary disseminated type, has a death rate often as high as 30 per cent. Table 1 shows the age distribution for the group. Eighty cases, or 64 per cent, were four years of age or under. Twenty-three per cent of the total number were under one year

TABLE 3.—Cases Showing Bacteremia

(PNEUMOCOCCIC)					
Age	Organism		Complication	Fatality	Pneumonia
	Blood	Sputum		No.	Per Cent Location
0-1	I	VII	Empyema Strept. V. Staph. A.		RUL
	I	0		1	16.6 LLL
	I	I	Empyema Typ. I.		RUL
2-4	XIV	0			RUL
	I	I	Leukemoid Reaction		RUL
	XII	Strept.			LLL
Total	6			1	16.6
(OTHER ORGANISMS)					
1-2	Staph. Aureus	XVII			RM RLL
2-4	Para-Ty- phoid B	VI			LLL
Total	2				

of age, and 23 per cent were between one and two years of age. Thus we had ample opportunity to see the effects of this drug in the age group in which pneumonia is so serious.

PNEUMONIA TYPES

We were able to obtain pneumonia types in only seventy-three cases or 59 per cent. Fifteen types were found, the most common of which were Types I, VII, XIV, VI, XXIII and IV in the order given. Table 2 shows the various types found and the age groups in which they were obtained.

BACTEREMIA

Eight cases had positive blood cultures and are tabulated in Table 3. Three of these were of Type I in ages 9 months, 2½ years and 9 years. Two were Type XII in ages 9 months and 2 years. One was a Type XIV in a 2-year-old child. Two children

TABLE 2.—Pneumococcus Types by Ages

Ages	TYPES																Total
	I	II	III	IV	VI	VII	X	XI	XII	XIII	XIV	XVII	XVIII	XIX	XXI	XXIII	
0-1					2	4	1		1	1	3		1	1		2	16
1-2				3	3	2				1	4	1				2	16
2-4	3			1	3	3					1					1	12
4-8	7	1				3					1						12
8-14	10	1	1			3			1		1			1	1		19
Total	20	2	1	4	8	15	1		2	2	10	1	1	2	1	5	75

TABLE 4.—*Estimated Duration of Disease When Drug Started*

Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14
No. of Cases	10	15	29	32	12	9	6	2	5	2	0	1	1	2
Per Cent	8	12	23	24	10	7	5				11			
77%														

showed blood cultures positive to organisms other than the pneumococcus. One 19-month infant showed *Staphylococcus aureus* on two consecutive blood cultures. The sputum showed Type XVII. In this case the temperature reached normal twenty-four hours after giving sulfapyridine. The lungs cleared by the fourteenth day. Treatment was stopped after three days. One boy, two years old, had two blood cultures positive for paratyphoid B. Cultures were taken at five-day intervals and the agglutination titer was 1-2560 and 1-5120, respectively. His stool cultures were negative. He was suffering with a left lower pneumonic consolidation. The sputum showed Type VI pneumococcus. The drug was continued for seven days though the temperature reached normal after four days of treatment. It did not rise again. All subsequent blood cultures were negative.

All of these patients with bacteremia made an uneventful recovery with the exception of one 9-month infant suffering from Type XII pneumococcus septicemia. Thus our mortality rate for the cases of pneumococcic bacteremia was 16.6 per cent.

DURATION OF THE DISEASE WHEN DRUG STARTED

When dealing with a disease that may end by crisis, it is possible wrongly to conclude that the rapid drop of the temperature was due to the drug used when, in fact, it was due to the normal crisis. Therefore, it is important that we have some knowledge of the duration of the disease when the drug was started. This of course could only be conjectured because we had to rely entirely on the history. Treatment as shown in Table 4 was started in 98 cases or 77 per cent by the fifth day of the disease. Thus we feel we can justly conclude that the uni-

TABLE 6.—*Time Required for Temperature to Reach Normal After Drug Started*

Day Normal	No. Cases	Per Cent	Complications	No.
1	75	59.5	Lung Abscess	1
2	31	24.6	0	
3	8	6.3	0	
4	3	2.4	0	
5	0	0	0	
6	2	1.6	0	
More than six days	6	4.8	Tuberculosis Empyema	1 5
Deaths	1	0.8	0	
Total	126	100.0		7

versal early drop of the temperature to normal was due, in the vast majority of cases, to the effects of the drug and not to normal crisis.

Table 5 shows an analysis of those twenty-nine patients sick longer than five days when the sulfapyridine was started. Since seven or 24 per cent of this number were bronchopneumonias in which the temperature is apt to be very protracted, and since in only two of the twenty-nine cases did it take longer than forty-eight hours for the temperature to reach normal, while nineteen or 66 per cent reached normal in twenty-four hours, we feel that we can also rightfully conclude that even these cases were beneficially affected by the drug.

TIME FOR TEMPERATURE TO REACH NORMAL

As stated above, one of the criteria for inclusion in this series was the severely ill child. High temperature was considered as one of the indications for the use of the drug. Eighty per cent of the group had temperatures above 103 degrees Fahrenheit, and 50 per cent above 104 degrees Fahrenheit when the drug was started. Many were above 106 degrees Fahrenheit. All temperature values are rectal.

The rapid drop of the temperature to normal was one of the spectacular effects of the drug. The time required for this to occur is visualized in Table 6. Eighty-four per cent had a normal temperature in

TABLE 5.—*Analysis of Cases Ill: Longer Than Five Days When Drug Started, Showing Diagnosis, Cases Not Typed, Time for Temperature Drop*

Days Ill	No. Cases	Type Pneumonia		No. Cases Not Typed	Temperature Normal		
		Broncho	Lobar		24 Hours	48 Hours	Longer
6	10	3	7	6	8	2	
7	6	0	6	3	3	2	1
8	2	0	2	1	1	1	
9	2	0	2	1	1	1	
10	4	1	3	2	3		1
11	1	1	0	0	1		
12	1	0	1	0	1		
13	1	1	0	0		1	
14	2	1	1	0	1	1	

TABLE 7.—Days Received Drug

Days	2	3	4	5	6	7	8	9	12
No. Cases	10	35	34	26	7	7	4	2	1
Per Cent	8	28	27	20	7	6	3	1	

forty-eight hours; however, in 59 per cent of the total cases this occurred in the first twenty-four hours of therapy. Those with pneumococcic bacteremia dropped as rapidly. Those cases that required longer than six days for the temperature to reach normal usually had some complication which the drug did not affect. The five cases of empyema which developed seemingly were unchanged in their course by the drug.

It was noted that with the drop in temperature a very large number—39 or 31 per cent—of the cases had subnormal levels which tended to persist for several days. Three cases had temperatures between 96 and 96.8 degrees Fahrenheit, while that of thirty-six cases ranged between 97 and 97.8 degrees Fahrenheit.

DAYS DRUG GIVEN

Table 7 shows the time the drug was given. This varied from two to twelve days. Eighty-three per cent received the drug not longer than five days. As we gained experience in this study we came to the conclusion that if the temperature did not reach normal by the fourth day, continuation of the drug would have little effect on the course of the disease. Early in the series we learned that sulfapyridine is a potent and dangerous drug; thus we concluded that long-continued administration should be avoided. If early drop in temperature did not occur, we were inclined to feel that other methods of therapy were indicated or the diagnosis should be corrected.

RESOLUTION OF LUNGS

While we have no controls to compare with this series, it is our impression that the time required for the lungs to become free of findings was not hastened by the use of sulfapyridine. The days required for the chest to clear is shown in Table 8.

It was the impression of the roentgenologist that resolution was even delayed. This he observed in

TABLE 9.—*Ages of Children Taking Longer Than Seven Days for Complete Resolution (Empyema-Lung Abscess Excluded)*

Age in Years	Total Cases in Age Group		Delayed Resolution		
	No.	Per Cent	No.	Per Cent Age Group	Per Cent Total Cases
0-1	29	23	15	33.5	12
1-2	30	24	14	31.5	11
2-4	21	17	4	9	3
4-8	23	18	6	13	5
8-14	23	18	6	13	5
Total	126	100	45	100	36

the adult cases treated with sulfapyridine also. This possibility is demonstrated in the case of an infant, one month old, who entered the hospital with a right upper and right lower lobe pneumonia due to a Type XIII pneumococcus. In five days she received 50 grains of the drug. Temperature dropped to normal in forty-eight hours. She remained in the hospital fourteen days. She was discharged with an unresolved right upper consolidation but with no fever. She has been closely followed in the outpatient department and has been admitted to the hospital on two subsequent occasions because of a definite acute pneumonic process in the right upper lobe. No pneumococci have been found in the sputum since the original infection. The right upper lobe is still unresolved six months after her original entry to the hospital. She remains fever-free except during the recurrent attacks of pneumonia involving this area. Only streptococci and staphylococci have been recovered in the sputum. Repeated tuberculin skin tests have been negative. The case which developed a lung abscess (to be described later) further confirms this contention of delayed resolution.

Only 68 per cent of the cases had no chest findings by the ninth day. It is interesting to note that of the forty-five cases (36 per cent) which took longer than seven days for complete resolution to occur, thirty-three cases or 74 per cent of those showing delayed resolution occurred in children under four years of age. This observation is visualized in Table 9. Thus it would seem that age was a

TABLE 8.—*Number Days Before Chest Cleared After Therapy (Death and Complications Excluded)*

Days		2	3	4	5	6	7	8	9	10	11	12	13	14	15	24	29	30	34	Longer
No.	Lobar	3	2	10	10	13	11	9	8	9	4	5	0	3	0	1	1	1	1	1
	Bronch	1	1	4	5	2	4	0	3	2	1	2	1	0	1					
Total		4	3	14	15	15	15	9	11	11	5	7	1	3	1	1	1	1	1	1
Per Cent		3	2	11	12	12	12	7	9	9	4	5	1	2	4					1
Deaths 1																				
Empyema 5																				
Lung Abscess 1																				

TABLE 10.—*Blood Concentration, Rectal Therapy*

Case	Concentration Milli-gram Per Cent	Type	Tem- pera- ture Normal	Compli- cation	Vom- iting
1	0.8—1.8	0	24 hrs.	0	0
2	1.8—7.5	0	24 hrs.	Empyema H. Strept.	0
3	2.1—3.4	III	24 hrs.	0	0
4	Tr.—4.1	IV	24 hrs.	0	0
5	Tr.—2.8	I	48 hrs.	0	0
6	3.3—8.9	I	48 hrs.	0	0
7*	1.0—4.6	VI	21 days	Tuber- culosis	0

* Case 7 had rectal therapy for nine days, no treatment for three days, then oral therapy for nine days. (186 grains each period.)

Concentration Compared (Analogous days)					
Oral	7.3	5.8	4.3	6.4	
Rectal	1.0	2.2	5.0	2.4	

factor in this delayed resolution when such children were treated with sulfapyridine.

It was consistently observed in these 126 cases that if consolidation was not massive when the drug was started such did not occur in the progress of the disease. In fact, the picture of pneumonia with which we are so familiar, changed so rapidly that it was with difficulty a sufficient number of typical cases of lobar pneumonia was found for the teaching service.

SULFAPYRIDINE BLOOD CONCENTRATION

We found the concentration of the drug in the blood stream a variable and unpredictable thing. This varied from a trace to a high of 17.9 milligrams per cent. It varied from day to day with the same dosage. Concentration was so variable that it was difficult to strike an average, but most cases varied between 4 and 8 milligrams per cent. An average of twenty-five cases picked at random showed a concentration for the first three days of therapy of 4.6, 5.0, and 4.2 milligrams per cent, respectively. The degree of concentration seemingly had little effect on the drop in temperature, coming as rapidly in weaker concentrations as in the stronger. We offer no explanation for this variability. The drug was excreted with variable speed but was usually completely eliminated in twenty-four to forty-eight hours.

The patient with the highest concentration was a 6-year-old boy. There was nothing unusual that would account for this high concentration. He had no kidney abnormality. He had a Type I pneumonia, being extremely toxic with a temperature of 106 degrees Fahrenheit at the onset of treatment. The concentration on successive days was 9.6, 14.5, and 17.9 milligrams per cent. This dropped to 6.3 milligrams per cent twenty-four hours after the drug was discontinued. His temperature dropped to normal in the first twenty-four hours of therapy and did not rise again. The only effect noted was the

drop of 22 per cent in his hemoglobin and one million in his red count. Similar drops were noted in other cases with a much lower blood concentration. This patient was discharged completely recovered and with a normal blood count.

We found the blood concentration when rectal therapy was used to be approximately half that of the orally treated cases. These patients so treated had a normal temperature in twenty-four hours, two in forty-eight hours, and one which had a Type VI pneumonia engrafted on a tuberculous background had a long and stormy course. Table 10 shows the minimum and maximum concentrations of the seven cases treated per rectum, the time required for the temperature to reach normal, and a comparison in one case of the blood concentrations on analogous days between the two methods of administration. In this particular case, because the temperature did not drop and resolution did not occur, treatment was continued for two successive periods of nine days each. (See Case 7 of Table 10.)

We are convinced we do not know the optimum blood concentration. With the present drug and method of administration we have no way of controlling the degree of concentration. It would seem that it is not necessary to have high concentrations to occasion effective results. One case showing a Type XII blood stream infection had only a trace of the drug in the blood at any time; yet the temperature was normal in twenty-four hours.

CHANGES IN THE BLOOD

While average white counts have little meaning, we quote the following averages in order to show the effect of the drug on the white blood cells. The average count at the beginning of treatment was 23,500 with 80 per cent neutrophils. When treatment was stopped the average count was 10,500 with 65 per cent neutrophils. On discharge the average count had dropped to 9,400 and 66 per cent neutrophils. We concluded that this drop in blood count to normal associated with a return to normal temperature indicated that active infection was at an end. There was no relationship, however, with this drop in the white blood cells and resolution of the pneumonia.

There were other blood changes about which we were not so happy. These adverse effects on the blood cells were the most common unfavorable findings noted with the use of sulfapyridine. Some were mild, others were alarming. They seemingly had no relationship to the amount of the drug given or to the length of time it was administered. These changes are outlined in Table 11.

Leukopenia, ranging from 2,300 to 4,800, occurred in ten cases or 8 per cent. In no case did this require stopping the drug. The effect of treatment was accomplished when the leukopenia appeared. One infant, 15 months old, developed a leukopenia of 4,600 one week after the drug had been discontinued. This followed four days of treatment with a total dosage of 90 grains. These low counts rapidly returned to normal without treatment.

Four cases started therapy with a white count ranging from 5,200 to 7,800. In each case there was rise in this count during the course of the dis-

TABLE 11.—*Blood Changes*

	No.	Per Cent Total Cases	Anemia Before Therapy					
			Low Hemoglobin			Low Red Blood Cells		
			No.	Changes	Per Cent	No.	Changes	Per Cent
Reduction of hemoglobin only								
Major *	15	12 $\frac{1}{2}$	16	4	25			
Minor †	35	28 $\frac{1}{2}$ 40 per cent						
Reduction of red blood cells only								
Major ‡	24	19 $\frac{1}{2}$				9	4	44
Minor §	29	23 $\frac{1}{2}$ 42 per cent						
Reduction of hemoglobin and red blood cells	18	14	7	7		7	7	
Leukemoid reaction ¶	1	0.8						
Leukopenia	10	8						

* More than 15 per cent.
 † Less than 15 per cent.
 ‡ More than 500,000.
 § Less than 500,000.
 ¶ Journal Pediatrics, Vol. 15:5,740, 1939.

ease and administration of the drug. Temperature in these cases did not drop to normal in a single instance in twenty-four hours. It required forty-eight hours in two cases, three days in another and six days in still another. Two of these cases showed no typing of the sputum.

There were significant changes (more than 15 per cent hemoglobin and 500,000 red blood cells) in the red cells and hemoglobin in thirty-nine cases or 31 per cent. Fifteen cases, or 12 per cent, had a drop in the hemoglobin ranging from 15 to 45 per cent. Twenty-four cases, or 19 per cent, had a drop in the red count ranging from 500,000 to 2,200,000. One was so dramatic and sudden that emergency blood transfusions were necessary. Thirty-five other cases, or 28 per cent, had minor reductions in the hemoglobin or red blood cells. Thus seventy-four cases, or 58 per cent, had reductions in the hemoglobin or red blood cells or both of sufficient degree to note.

Of the thirty-nine cases showing major reduction in the red blood cells and hemoglobin, twenty-five, or 65 per cent, had a hemoglobin below 60 per cent and a red count below 3,750,000 at the start of treatment. It was this group of anemic individuals that was most affected by the drug. In this group there were sixteen cases which started treatment with a low hemoglobin, yet four, or 25 per cent, had severe reductions. Of nine cases which had a low red count when treatment was started, four, or 44 per cent, had severe reductions. Thus it would seem that those patients which have an anemia at the beginning of treatment offer a special hazard when sulfapyridine is used.

We have already published¹ one blood reaction that was strange and severe. This was in a 9-year-old Mexican boy who had a severe Type I pneumonia with a Type I bacteremia. He received the usual dosage. His temperature returned to normal in twenty-four hours. Treatment was stopped after three days. Two days later there was lassitude, temperature of 102 degrees Fahrenheit, marked pallor and slight icterus. In twenty-four hours the red cells dropped from 3,240,000 to 1,380,000 and the hemoglobin from 60 per cent to 22 per cent. The

white count increased to 81,000 and showed a leukemoid shift with 22 per cent myelocytes. After several blood transfusions this boy was discharged, five weeks after entry, fully recovered and with a normal blood count. During the time of his acute reaction he had a hemoglobinuria lasting two days.

URINARY CHANGES

Urinary changes were as a rule not significant. Some abnormal condition as shown in Table 12 was noted in twelve cases. But in seven of these the casts, albumin and white blood cells that were found, might have been due to the pneumonia. Free hemorrhage was seen in four cases, or 3 per cent. One of these was quite severe, occurring over a period of several hours. All hemorrhage stopped on the withdrawal of the drug and no aftermath was noted. None were severe enough to warrant transfusions or treatment for an anemia. In one case the hemorrhage was preceded by severe abdominal pain of several hours' duration. Needle-like crystals of acetyl sulfapyridine were seen in the urine of one of these hemorrhage cases. The hemoglobinuria which occurred with the leukemoid reaction has already been mentioned.

SYMPTOMATIC REACTIONS

Symptomatic reactions as shown in Table 13 were rare. Nausea and vomiting were noted in eight cases, two of which were severe enough to warrant stopping the drug. No case receiving the drug per rectum vomited. Mental confusion was present in eight cases. This ranged from mental apathy to ex-

TABLE 12.—*Urinary Changes*

	Number	Per Cent
Hemorrhage	4	3
Casts and albumin	3	2.4
Hemoglobin	1	0.8
Acetylsulfapyridine crystals	1	0.8
White blood cells	4	3

TABLE 13.—Symptomatic Reactions to Drug

Reaction	Number	Per Cent
Nausea and vomiting	8	6.3
Mental confusion	5	3.9
Cyanosis	3	2.4
Restlessness	3	2.4
Anorexia	1	0.8
Muscular twitching	1	0.8

treme restlessness, marked disorientation and irrationalism. These conditions rapidly disappeared on withdrawal of the drug. Muscular twitching, associated with extreme restlessness and mental confusion, was of such severity in a child one year old that the drug was discontinued before the temperature reached normal. Cyanosis was noted in only three cases. This symptom did not seem to be as common as in those children receiving sulfanilamide. Extreme anorexia was noted in one case.

COMPLICATIONS OF THE DISEASE

The complications which developed with the disease are shown in Table 14. Five cases developed empyema. Two of these had definite evidence of pleural irritation on entry to the hospital. Both had Type I pneumococcus in the sputum and in the pleural exudate. One of the two had a positive Type I blood culture. Another patient, whose sputum and blood showed no type, presented some questionable pleural involvement on entry. This pleural exudate also showed Type I pneumococcus. Sulfapyridine had no effect on the development or course of the empyema.

One other empyema was due to a hemolytic streptococcus. This case had no sputum type or blood culture. Diagnosis was a diffuse bronchopneumonia. Sulfapyridine was given by rectum for one week. There was a gradual decline in temperature to normal. When the drug was stopped the chest was clinically clear. After remaining well for one week, a definite consolidation occurred in the left upper lobe. Sulfapyridine was again started by mouth but with no effect. Empyema developed rapidly.

Another 9-month infant had a right upper lobe consolidation. Sputum showed Type VII and blood showed Type I pneumococcus. Because of the severe anemia and poor nutritional state, a blood transfusion was given before the sulfapyridine was started. There was no response to the drug even though continued for eight days. It was stopped because of the severe anemia. The blood concentration ranged from 2.2 to 4.8 milligrams per cent. Blood cultures continued positive for two weeks. By the third week x-ray showed almost complete resolution of the lung but with a slight pleural exudate. With the disappearance of the blood stream infection the high fever became low grade. The pleural effusion gradually increased until rib resection was done. The exudate showed Streptococcus viridans and Staphylococcus aureus. All five cases of empyema made an uneventful recovery after surgery.

TABLE 14.—Complications of Disease

	Number	Per Cent	Fatality
Empyema	5	5	0
Otitis media	4	3.1	0
Bacteremia	8	6.3	1
Lung abscess	1	0.8	0
Total	18	15.2	1

One 3-year-old boy developed a lung abscess. The right upper lobe consolidation was due to a Type XXIII pneumococcus. Blood cultures were negative. The temperature dropped to normal in twenty-four hours, where it remained for eight days. During this period no change was noted in the consolidation. X-ray eventually demonstrated a cavity in the midst of the consolidation. No culture was obtained from the cavity. Recovery was complete with symptomatic treatment in three months.

MORTALITY

The only death in our series was that of a 9-month Mexican infant, sick for five days before entering the hospital. He was extremely toxic, cyanotic and dyspneic. The sputum did not type, but the blood culture showed Type XII pneumococcus. The child died less than forty-eight hours after therapy was started. No beneficial effects of the drug were noted after 52 grains had been given. The blood concentration was 8.6 milligrams per cent on the first day of treatment and 13.5 milligrams per cent on the day of death. The urine was negative. This one death gives the remarkable death rate of only 0.8 per cent.

SUMMARY

This paper represents a study of 126 cases of pneumonia in children under fourteen years treated with sulfapyridine at the Los Angeles County General Hospital from March through December of 1939. Ninety-nine of the total number of cases were lobar pneumonias and the remaining twenty-seven bronchopneumonias.

Criteria for sulfapyridine therapy were established arbitrarily as follows: (1) clinical diagnosis of severe, toxic pneumonia; (2) x-ray confirmation of physical diagnosis; (3) blood count; (4) urinalysis; (5) blood culture, and (6) sputum typing. Once the drug had been started the routine was (1) daily chest examination; (2) complete hemogram every twenty-four to forty-eight hours during the period of sulfapyridine administration and every three days thereafter; (3) urinalysis every three or four days; (4) check x-ray one week after the temperature had reached normal if the lungs were clinically clear, and (5) sulfapyridine blood concentration daily at the same hour.

Dosage of the drug was calculated on the basis of 1 to 1.5 grains per pound of body weight, the daily dose not to exceed 90 grains in any twenty-four-hour period. The total dose was divided by six and given at four-hour intervals day and night, the initial amount being double the calculated four-hour dose.

The length of time of drug administration varied from two to twelve days. Eighty-three per cent of the total number did not receive the drug longer than five days.

The time required for the temperature to reach normal varied. In 84 per cent of the cases normal temperature was reached in forty-eight hours; in 59 per cent of the total cases this occurred in the first twenty-four hours. Cases requiring longer than six days usually had some complication which the drug did not affect. It is interesting to note that 31 per cent (thirty-nine cases) had subnormal temperatures which persisted for several days.

The blood concentration of the drug was unpredictable. It varied from a trace to a high of 17.9 milligrams per cent. No explanation is offered for this variability. When the drug was given rectally we found the blood concentration to be about half that of the orally treated cases.

Complications of the drug and the disease are discussed at some length.

Mortality for the entire series is 0.8 per cent.

CONCLUSIONS

With the experiences gained in this study we feel justified in drawing the following conclusions:

1. Sulfapyridine is a very effective drug that should be used in every clearly defined pneumococcic pneumonia in children.

2. It is reasonable to expect that sulfapyridine or related compounds will replace all other methods of routine treatment in the pneumococcus pneumonias in pediatrics practice.

3. The routine use of sulfapyridine in clearly defined pneumococcic pneumonias in childhood should markedly reduce the present death rates in this disease.

4. Sulfapyridine is a toxic and dangerous drug especially affecting the blood, blood-forming organs and the kidneys. Every case in which the drug is used is fraught with potential difficulties which may come with alarming suddenness and severity.

5. The drug should never be used unless the patient is completely under the control of the physician who should resort to frequent blood counts and urinalyses.

6. The drug should not be continued over long periods.

7. The drug apparently does not hasten the time of complete resolution and may even slightly retard it.

8. When treated early with sulfapyridine, the lobar pneumonias do not seem to progress on to the massive consolidation so frequently seen in the untreated case.

9. Routine determination of blood concentration is not necessary since no definite level can be established.

10. The degree of blood concentration seemingly has little effect on the speed with which the drug acts or with its ultimate effectiveness.

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POLYPOID BRONCHIAL TUMORS*

WITH SPECIAL REFERENCE TO BRONCHIAL ADENOMATA

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POLYPOID bronchial tumors are those neoplasms which grow as projections within the bronchial lumen and are visible through the bronchoscope. Until a short time ago, all invasive polypoid bronchial tumors were believed to be malignant. Recently,^{1,2} however, polypoid bronchial adenomata have been separated, clinically and pathologically, from the other polypoid tumors, to form a new clinical entity—a polypoid bronchial tumor which, though locally invasive, rarely metastasizes and can be cured.

TYPES OF POLYPOID TUMORS

Since bronchial adenomata are polypoid in form, though nonmetastasizing, and comprise some 6 per cent³ of all bronchial tumors, it becomes important to classify polypoid tumors in order to select the proper therapy. Three types may be distinguished, namely:

Metastasizing polypoid tumors (carcinoma).

Locally invasive, but nonmetastasizing polypoid tumors (adenoma).

Noninvasive, nonmetastasizing, purely local polypoid tumors (fibroma, lipoma, myoma, and so forth).⁴

The importance of this reclassification, and the recent separation of adenomata from carcinomata, are demonstrated by a review of some of the publications which resulted from their confusion. It seems most probable that certain reports of the successful removal of carcinoma of the lung by means of the bronchoscope,⁵⁻⁹ and of the cure of carcinoma of the lung by pneumonectomy,¹⁰⁻¹³ or deep x-ray therapy,^{14,15} actually refer to cases of adenoma.

The various names by which the clinical entity now termed "bronchial adenoma" has been designated have added still further to the confusion. Geipel,¹⁶ in 1931, termed these tumors "basal-cell cancer"; Wessler² (1932), "benign bronchial adenoma"; Kernan¹⁷ (1935), "carcinoid"; Moersch⁸ (1935), "adenocarcinoma"; Clerf and Crawford¹⁸ (1936), "benign glandular tumors"; Zamora and Schuster,¹⁹ (1937), "vascular adenoma"; Welt and Weinstein,²⁰ (1937), "endothelioma"; and, finally, Womach and Graham²¹ (1938), "mixed tumors of the lung." Yet, undoubtedly, each of these authors referred to the same type of tumor.

RELATION TO AGE AND SEX

The age of the patient at the onset of symptoms of adenoma is strikingly different from that of

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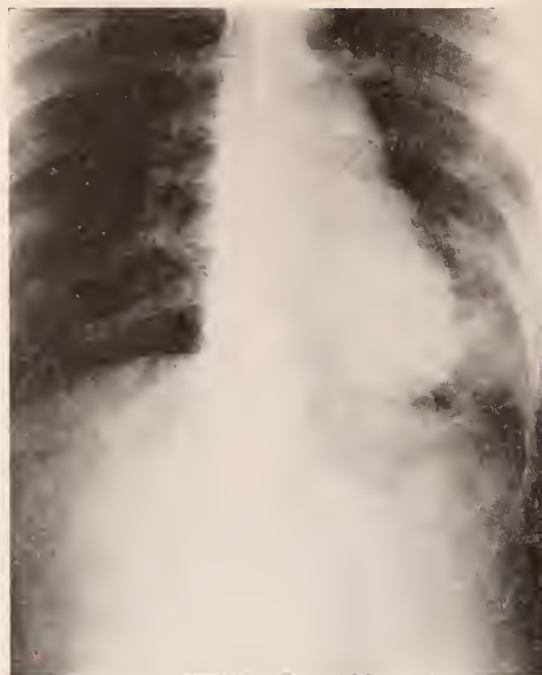


Fig. 1

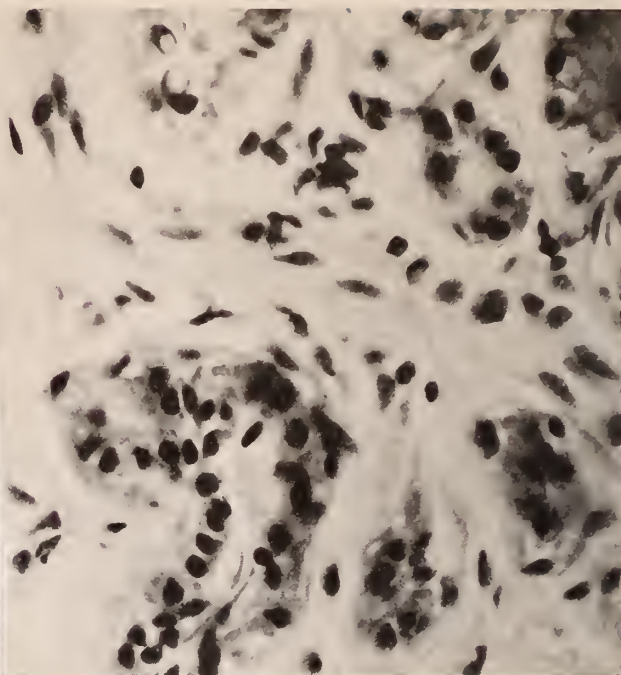


Fig. 2

Fig. 1 (Case 1).—Postero-anterior view showing the cystic whorls behind the left border of the heart. The barium in the esophagus shows no external pressure defects.

Fig. 2 (Case 1).—Photomicrograph (750 x) of the specimen removed at bronchoscopic biopsy from the endobronchial portion of the adenoma obstructing the mediastinal branch of the left lower lobe. Note the alveolar patterns and pyknotic nuclei. Compare with Fig. 3.

patients with carcinoma. In our group of eighteen patients with bronchial adenomata, twelve, or 66⅔ per cent, had symptoms before the age of forty years, in contrast to only 13 per cent of those with carcinoma, as shown in Fischer's²² large series, and 11 per cent in Brunn's.²³

The distribution by sex is likewise in marked contrast to that of carcinoma. In our eighteen cases of adenoma, ten, or 56 per cent, were females, whereas only 25 per cent of carcinomata occurred in females in Simpson's²⁴ and Gazagerli's²⁵ series.

In prognosis and duration of life, also, patients with adenoma present a marked contrast to those

with carcinoma. If all cases of probable adenoma which have been reported as carcinoma are excluded, a few probable "five-year cures" of true bronchial carcinoma remain^{26, 27, 11, 9, 28, 29}; the prognosis for patients with adenoma, on the other hand, is very good, and many "five-year cures" have been reported. In our series, for example, all the patients but one lived more than three years after the onset of the symptoms; fourteen lived more than five years. These figures are noteworthy since, in Brunn's²³ cases of carcinoma, only 4 per cent of 297 patients survived three years or longer.

SYMPTOMS AND CLINICAL COURSE

The symptoms and clinical course of bronchial adenomata are related to three peculiarities of their life history: first, their location in a major bronchus; second, their slow growth; and, third, their vascularity.

Any lesion encroaching upon the lumen of a large bronchus gives rise to symptoms of bronchial obstruction, and the first symptoms of these tumors result from disturbance in the transference of air along the large bronchial tubes. Wheezing, "asthma," irritating, nonproductive cough, dyspnea, transient chest pains, "choked-up sensations" and respiratory postural discomfort are thus the initial symptoms to appear. These are often so indefinite or transient as to be entirely overlooked unless they are very carefully inquired for. When air becomes completely shut off from the alveoli distal to the tumor, atelectasis results, and this occurred in seventeen of our eighteen patients. On the other hand, when air is entrapped distal to the tumor, emphysema occurs.



Fig. 3 (Case 1).—Photomicrograph (120 x) of a section of the extrabronchial portion of the tumor, showing the more definite alveolar pattern and its uniformity. No mitotic figures could be seen.



Fig. 4a

Fig. 4b

Fig. 4c

Figs. 4a, 4b, 4c (Case 1).—Serial selective "spot films" showing cystic dilatations in the mediastinal section of the left lower lobe.

As the tumor grows, the bronchial obstruction also interferes with the drainage of bronchial secretions; consequently, the next symptoms to appear are those of pulmonary suppuration. Recurring "pneumonias," or so-called drowned lung, are most common; but empyema, abscess and bronchiectasis are frequent. Twelve of our eighteen patients had marked symptoms of pulmonary suppuration, while the remaining six had only slight symptoms of suppuration, although bronchial obstruction was present. The obstructions in five of the latter, however, were in the upper lobe bronchi, and only one was in the lower lobe. When death occurs it usually is the result of the suppuration or an infection complicating the therapy.

The slow growth of these tumors allows time for permanent chronic inflammatory changes to occur in the lungs and pleura. Thus are produced chronic suppuration and toxemia, which give rise to easy fatigue, low-grade fever, chronic cough, sputum, pleuritic pains, dyspnea on slight exertion, anemia, anorexia, and all the symptoms usually associated with pulmonary tuberculosis. In six, or 33⅓ per cent of our patients, the erroneous diagnosis of pulmonary tuberculosis had previously been made.

The cardinal symptom of bronchial adenoma is the pulmonary hemorrhage associated with the extreme vascularity of these tumors. These hemorrhages are characteristically sudden in onset and termination, bright red in color, profuse even to the extent of producing shock, unprovoked by cough or exercise; and, in women, frequently occur during the menstrual period. This hemorrhage probably arises from the tumor itself. A second type of hemorrhage, associated with the distal suppuration, is just as frequent. It is composed of dark blood, often clotted and mixed with pus; is induced by cough and exertion, and is followed by blood-streaked sputum for several days. Pulmonary hemorrhage was a cardinal symptom in twelve, or 66⅔ per cent of our patients. This, however, has been reported as the immediate cause of death in only one case.³ All the symptoms described are

related to the endobronchial portion of the tumor; few symptoms or none are produced by the extra-bronchial or mural portions.

Roentgenologically, the appearance is bizarre; but, characteristically, lobar atelectasis is present.³⁰ Disturbances in aeration characterize the picture, so that varying degrees of emphysema and atelectasis are present. A marked shift of the mediastinum, thick pleura, cystic whorls and abscess cavities represent the results of the suppuration. The tumor itself is rarely demonstrated, usually because of the inflammatory changes overlying it.

Bronchography, particularly with "endobronchial probing,"³¹ is valuable in determining the level of the bronchial obstruction and the condition of the distal bronchi.³² (Figs. 4a, 4b, 4c, 4d, Case 1.)



Fig. 4d.—"Spot film" showing the filling defect (arrow) at the site of the endobronchial portion of the tumor.



Fig. 5 (Case 1).—Specimen removed at lobectomy (left lower lobe), demonstrating cystic bronchiectasis limited to the mediastinal segment of the left lower lobe.

The bronchoscopic image is that of a soft or firm mass or polyp, whitish, pink or purple, not cystic, and, if of long duration, indurated and hard. These tumors are covered with mucosa and occasionally vessels traverse the bosselated surface. Their attachment to the bronchial wall is usually no more than a centimeter in diameter, and when this tumor is removed its stalk may be seen descending between the cartilaginous rings. The bronchus around the tumor is distended and its cartilages are thinned out or even absent.

DISTRIBUTION IN AUTHOR'S STUDY

In eleven (61 per cent) of our patients, the adenoma was on the left side, and in seven, or 39 per cent, on the right. Carcinoma, on the other hand, occurs slightly more often on the right side than on the left—53 per cent on the right in Fischer's²² 3,435 cases; 57 per cent on the right in Brunn's²³ series. In our patients the lobes and bronchi were involved in the following order: left stem, 5; right stem, 4; left lower, 4; left upper, 2; right upper, 2; right lower, 1; and right middle, 0.

Three forms of adenoma were found in our group:

1. Endobronchial, usually with a small pedicle—five patients.
2. Intramural, usually with a broad pedicle—four patients.
3. Endo-extrabronchial, dumbbell-shaped, with the extrabronchial portion usually the larger—nine patients.

HISTOLOGY

Histologically,^{3,21} bronchial adenomata are characterized by a uniformity of cell type, absence of mitotic figures and a tendency for the cells to be grouped in an alveolar arrangement. Covering the tumor is the mucosa, which usually undergoes squamous-cell metaplasia and is separated from the epithelial portion of the tumor by a dense membrane of fibrous tissue. Beneath this membrane the epithelial surface is highly vascular.

Histological diagnosis of adenoma from the material removed at bronchoscopic biopsy is not easy, because the tissue obtained often is not deep enough within the tumor to show characteristic patterns. Squamous-cell carcinoma, because of the squamous-cell metaplasia present on the mucosal surface; angioma due to the vascularity just beneath the connective tissue capsule, or inflammatory tissue when the epithelial surface has been traumatized, may be diagnosed instead of adenoma.

TREATMENT

Treatment of the bronchial adenoma requires, first of all, the relief of toxemia by the reestablishment of bronchial drainage.³³ This is accomplished by bronchoscopic removal of the endobronchial portion of the tumor. If disabling symptoms from the residual pulmonary suppuration persist in spite of postural drainage, lobectomy or pneumonectomy is required. It does not appear to us necessary for the maintenance of life to remove the tumor *in toto*. Residual mural portions of the tumor apparently remain quiescent for years. If, on repeated clinical, bronchoscopic and roentgen examinations, the residual mural or extrabronchial portions of the tumor show signs of an increased rate of growth, pulmonary resection is indicated. Deep x-ray therapy may offer some benefits, but we have seen no direct evidence that this form of therapy affects the tumor *per se*. Complicating suppurative disease, such as abscess or empyema, or both, may require surgical drainage.

Of the eighteen patients, thirteen are still living. Of these, two had pneumonectomy, one had lobectomy, four had bronchoscopic removal of the tumor, and six had deep x-ray therapy. Five patients died; one after pneumonectomy, one after bronchoscopic cauterization, and one after numerous bronchoscopic drainages (the tumor was not removed). The remaining two had no treatment; the diagnosis was made at necropsy.

The case reported below illustrates most of the salient features of the bronchial adenoma.

REPORT OF CASE

CASE 1.—F. J., a white female, 26 years of age, was admitted to the San Francisco Hospital (Tuberculosis Service of Dr. S. Shipman) on August 31, 1938. Her illness began in 1932 with wheezing and "asthma," followed by pulmonary hemorrhages, sudden in onset and termination, often occurring with the menses. During the next six years the hemorrhages were replaced by febrile periods terminating with the expectoration of bloody fetid sputum. The latter became more frequent until they were occurring every three weeks at the time of her admission to the hospital.

X-ray examination showed cystic whorls behind the left border of the heart (Fig. 1, Case 1); these shadows varied

in appearance from time to time. Repeated examinations of the sputum failed to reveal tubercle bacilli.

The clinical diagnosis was tuberculosis of the lungs. The patient had been treated by several physicians, and bronchoscopic and lipiodol examinations had been performed without demonstrating the pathological changes.

Bronchoscopy, done at the San Francisco Hospital in August, 1938, showed a small polypoid tumor obstructing the mediastinal branch of the left lower lobe (Fig. 4d, Case 1). Biopsy proved this tumor to be an adenoma (Fig. 2, Case 1). Endobronchial probing with serial selective bronchography³¹ showed cystic bronchiectasis limited to the mediastinal segment of the left lower lobe (Fig 4a, 4b, 4c, 4d, Case 1).

A one-stage lobectomy (left lower lobe, Fig. 5, Case 1) was performed on October 10, 1938. The patient's convalescence was uncomplicated. The pedicle of the tumor left in the stump was not visible through the bronchoscope one month after operation. The extrabronchial portion of the adenoma which was removed showed the typical cellular pattern of an adenoma (Fig. 3, Case 1).

Eight months after operation the patient was free from symptoms, and bronchoscopy again showed no visible tumor.*

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CLINICAL NOTES AND CASE REPORTS

GASTRIC CARCINOMA: PITFALLS IN EARLY DIAGNOSIS*

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WE all acknowledge without debate the distressing difficulties arising in the diagnosis of early carcinoma of the stomach. The importance of early recognition shall well be appreciated when we note that one-third of deaths from cancer in the United States originates in the stomach. Stereotyped, textbook description of gastric carcinoma with absence of free hydrochloric acid, enlarged lymph nodes, occult blood, or the presence of tumor tissue in stomach washings, are not infrequently premortem findings and beyond the stage of surgical redemption. Incipient cases, on the other hand, present symptoms that are notably

* The author wishes to acknowledge the assistance and advice given by Dr. Harold Brunn and other members of the staff of the University of California Thoracic Surgery services, who contributed so unselfishly many of the ideas and much of the material for this paper.

* Read before the staff of St. Joseph's Hospital, Eureka, January 18, 1940.

vague and indefinite, as heart-burn, nausea, distention, or belching, and are usually diagnosed as chronic gastritis. If malignancy is suspected, a complete gastric investigation is undertaken often to bewilder the internist with such reports as negative laboratory findings, negative radiographic readings and negative gastroscopical interpretations. A few months later the patient may take a rapid malignant course, the findings may all be strongly positive, and a radical extirpation of the tumor may then become impossible. Having recently observed such an incidence, this is the motive for the preparation of this paper.

EXAMINATION PROCEDURE

Let us review for a moment the usual procedure taken in the investigation of a gastric carcinoma. We are mindful that stomach carcinoma lesions may take one of three forms:

1. As an ulcer.

(Let us note that 86 per cent of stomach ulcers are situated in the posterior surface of the lesser curvature, and of these over one-half may be malignant.)

2. The carcinoma may appear as a fungating mass projecting into the lumen.

3. As a diffuse infiltrating form with no real tumor demonstrable, simulating linitis plastica clinically.

A busy, middle-aged man is likely to come to your attention for relief for a dyspepsia. He gives a story of having a certain amount of mild discomfort, as gas in the stomach, or, as he described it . . . "a case of nervous indigestion" for the past several weeks or so. He says he suffers no pain. Yet 50 per cent of early gastric carcinoma is painless. Those having pain as an early symptom begin as an ulcer, or as a tumor at the pylorus, because of spasmodic contraction of the muscle. A tumor in other parts of the stomach is usually painless.

Upon examination you may find the individual to be well nourished, with nothing superficially to denote anything but possibly a case of chronic gastritis or some such disorder. You put him on a diet and improvement is noted, at least temporarily. Even cancer symptoms usually vanish under strict medical management. The x-ray ranks foremost in the spotting of gastric carcinoma. But it has its shortcomings; it does not always spot them. Gastroscopy is invaluable, but gastroscopists are scarce, and then there are patients who cannot withstand the ordeal. Gastric analysis is disappointing. The absence of free hydrochloric acid in the stomach is a recognizable feature in cancer, yet several cases have been reported with hyperacidity even in advanced carcinoma. In early malignancy free hydrochloric acid is often present. Again, if it is absent the case is usually inoperable, or the patient has simply a chronic gastritis. If the early tumor is localized to the pylorus, there is no change in the acid ratio in the stomach, as the pylorus contains no acid-producing glands. The presence of lactic acid alone does not signify cancer, but when found in the absence of hydrochloric acid it usu-

ally spells malignancy. Which goes to prove that when positive findings are demonstrated, when supraclavicular glands have become apparent, or when the Boas-Oppler bacilli make their appearance, we are not dealing with an early carcinoma of the stomach that may be amenable to surgery, but are facing a hopeless and inoperable disease. Clinically, negative findings is the rule in early gastric carcinoma.

REPORT OF CASE

A business man of sixty-two came to my office last June, 1939. He had a very nervous feeling about the stomach, but free from abdominal pain. He complained of excessive gas in the stomach, belching violently after meals. Gas in the stomach began five years ago, which was aggravated by condiments and wine in the diet. He had learned that the avoidance of the usual rich sauces reduced his after-dinner distress. Soda gave him relief. Weighing 180 pounds, he had not lost weight in the past five years.

Family History.—His father and mother lived to ripe old age. No cancer in the family.

Past History.—Usual childhood diseases. Influenza, with pleural effusion in 1928; recovered. Father of two healthy sons.

Physical Examination.—Robust, Italian, a baker by trade. Pulse 90, good quality. Blood pressure, 146/90. Temperature, 98 degrees Fahrenheit. Moderate degree of nervousness. Patient complained of insomnia. No night sweats. No coughs. No tremors. Respiration, 20. Lungs: crepitant râles in left base. No cervical adenopathy. Thyroid not palpable. Eyes reacted normally to light accommodation. Ears, nose, and pharynx were negative. Mucous membrane of mouth was clear. Teeth excellent.

Heart.—No murmurs or irregularities or enlargement. No edema or ascites.

Abdomen.—No distention. No rigidity. No definite palpable mass. Liver and spleen not palpable. No epigastric tenderness. No enlarged inguinal glands. Genitalia normal. No evidence of hernia.

Rectal Examination.—Blumer's shelf, negative. Prostate was moderately enlarged. No urinary symptoms.

Laboratory Findings.—Urinalysis was negative. Blood count and differential, normal. Hemoglobin, 90. Wassermann and Kahn, negative.

Gastric Contents.—No occult blood, no Boas-Oppler bacilli, and the microscopic examination was negative. The free HCl was 10 degrees for the fasting specimen, and the same for the thirty- and sixty-minute specimens. The combined acid was the same, that is, 10 degrees throughout.

X-Ray Report.—Cholecystogram was negative. Fluoroscopic examination of the chest showed the aortic area to be widened. The esophagus appeared normal. The stomach was of transverse type and filled out at a fairly high level. Under the fluoroscope, and on all the films, there was a filling defect about four inches proximal to the pyloric antrum. At the end of six hours the stomach was empty and barium had reached the transverse colon. At the end of twenty-four hours some barium was scattered throughout the colon.

A barium enema was administered and the colon was shown to be patent throughout and free from abnormal defects in outline. The descending portion was somewhat tortuous. The appendix was shown to be partially filled out. A film after evacuation shows a few bud-like areas extending out from the lumen of the descending portion of the colon.

Conclusion.—The area on the lesser curvature resembles a benign polypoid growth. There may be some ulceration around this growth. It might be well to make a reëxamination in a few months to see if any progress is being made.

There is diverticulosis of the descending colon and sigmoid.*

* By J. S. Woolford, Eureka.

A second x-ray examination, a month later, was reported as follows:

The stomach is irregular in outline, which is probably due to a fold in the mucous membrane.

The antrum is lying posterior. Duodenal cap is large, smooth.

Conclusion.—Reduplicate mucous membrane middle third of the stomach, giving the appearance of a deformity, although a polyp is not entirely excluded.[†]

Both x-ray reports admit the possibility of a polyp . . . but solitary polyps in the stomach are extremely rare, multiple polyps being the rule.

1 1 1

Gastroscopic Interpretation.—The antrum and pylorus were fairly well seen, the pylorus appearing patent and no contractions being observed over a period of several minutes. The mucosa in the region of the angulus (incisura) appeared very irregular, stiff, and *definitely* hypertrophic. The entire antrum was distorted owing to this hypertrophied character of the mucosa.

On the posterior wall, nearer to the lesser curvature, a marked inward bulging or protrusion of the mucosa was observed. The mucosa was moderately hyperemic and stiff-looking. It was interpreted as a very hypertrophied fold, extending upward from the angulus (incisura) and occupying most of the mid-portion of the stomach on the posterior wall. Inflation of air did not depress this prominent fold. On the lesser curvature and anterior wall of the body of the stomach, just proximal to the incisura, the mucosa was also very irregular and hypertrophied. Several small hemorrhagic areas were seen here. No polyp was observed. Several whitish, streaked areas were observed in the body, which were probably retained barium ingested recently. This material would tend to obscure any small ulcerations.

Impression.—Was that of a severe, diffuse chronic hypertrophic gastritis, involving the lower half to two-thirds of the stomach, the lesion being most prominent at the junction of the middle and distal thirds, on the posterior and anterior wall, near the lesser curvature. No polyp was observed.

In the Differential Diagnosis.—It is necessary to consider the presence of a diffusely infiltrating carcinoma and gastric syphilis. The latter can be excluded by a negative serology. The former has frequently been confused with severe hypertrophic gastritis. But the clinical history, roentgen findings, and the gastroscopic appearance of the lesion favor the diagnosis of a severe, diffuse hypertrophic gastritis. Observation of the patient would seem highly advisable as to his response on a medical regimen.[‡]

COMMENT

Having exhausted all diagnostic procedures, what is the diagnosis? Carcinoma is ruled out because of the history of the patient. There is no loss of weight, no occult blood, no pain, nothing suggestive in any of the laboratory findings. The x-ray and the gastroscopic reports both lean on the benign side. The only real positive finding is a thickened fold of the mucosa near the pylorus. The diagnosis: Hypertrophic gastritis; with the recommendation that the patient be placed under medical régime and a reexamination in three months, gastroscopically and by x-ray.

Three months later, because of an intercurrent pneumonia, the patient was not able to report for further gastric investigation. A mass, by this time, had become apparent over the right upper quadrant. It was the size of a large orange and tender to palpation. There was a moderate abdominal rigidity and increased distention. Belching was severe. Food intake had lessened considerably. There was

a definite aversion to meat. The patient had lost ten pounds in the past three months.

An x-ray examination at the time revealed the following:

The stomach was markedly displaced to the left by what appeared to be an extrinsic mass. The distal portion of the stomach was narrowed in caliber, but peristaltic waves appeared to move through the area. There was considerable retention at the end of six hours.

Primary malignancy to the pars pylorica cannot be ruled out, but the appearance was that of pressure from an extrinsic mass.[§]

SUBSEQUENT COURSE

On November 13, 1939, just five months following his initial examination, exploratory operation was performed on the patient, which revealed a stone-hard induration of the stomach, confined principally to the posterior wall from the pylorus to the cardia. The stomach was fixed. The anterior wall appeared to be free from gross pathology. No enlarged lymph nodes were observed. The pancreas and the spleen seemed normal to palpation. The liver showed large, yellowish-white spots at the inferior surface, which was considerably bulged by a tumor mass the size of a large orange. The mass upon incision was soft and mushy. Its microscopic examination showed adenocarcinoma, which was to a great part degenerated and necrotic tissue. The stomach was infiltrated with scirrhus carcinoma. Condition inoperable. The patient expired four days later.

COMMENT

Scirrhus carcinoma of the stomach, or so-called leather-bottle stomach, is often impossible to differentiate from hypertrophic gastritis, either clinically, or radiographically, or gastroscopically. In both instances the mucosa may appear alike. In both instances the infiltration occurs between the inner and outer walls of the stomach, often with a thickening of an inch or more.

It is interesting to note the incidence of gastric carcinoma in dyspeptics. R. Schindler (*American Journal of Medical Science*, 197, 509, 1939) reports gastroscopic findings in one thousand patients in the United States as follows:

- 7.7 per cent had gastric carcinoma
- 22.2 per cent had normal stomachs
- 41.8 per cent had chronic nonspecific gastritis
- 2.2 per cent had benign tumors
- 8.0 per cent had postoperative stomachs
- 7.1 per cent had peptic ulcers
- 5.6 per cent had localized gastric purpura.

According to the literature, 6 per cent of gastric carcinoma is of the scirrhus type.

This case is a good example of the difficulty in differential diagnosis of diffusely infiltrating tumors: between severe hypertrophic gastritis and carcinoma. It is a good example of the rapidity of the disease toward a fatal termination. One cannot overemphasize the importance of frequent reexaminations and even of early exploration in the search for a positive diagnosis.

First National Bank Building.

§ By J. S. Woolford.

† By J. Levitin, San Francisco.

‡ By Rubin L. Gold.

ULCER OF THE JEJUNUM: ACUTE PERFORATION

By GEORGE A. WOOD, M. D.

AND

EDWARD LISTON, M. D.

Palo Alto

THE rarity of the lesion in this patient justifies a case report, especially since the history and findings resembled those of acutely perforated peptic ulcer.

REPORT OF CASE

T. S., a 63-year-old white laborer, was seized without warning by severe pain felt throughout the abdomen. This appeared while he was lifting heavy timber, and persisted continuously, becoming gradually more severe. There was no colic; no nausea nor vomiting, nor other symptoms.

His past history was strictly uneventful, except for repair to a right indirect inguinal hernia some twenty years ago. He had recurrence of the hernia, but was well supported by a truss.

On examination he was in extreme pain. The abdominal wall was hard, and the most tenderness was in the lower right quadrant. The pulse was 94 beats per minute, and regular. The blood pressure was 145 millimeters mercury systolic, and 60 millimeters mercury diastolic. The chest was negative. There was a small painless recurrent right inguinal hernia, and the old herniotomy scar.

He was given morphin sulphate, one-quarter grain, without improvement, and was hospitalized immediately. His white blood cell count was 18,000 per cubic millimeter of blood, 90 per cent being polymorphonuclear leukocytes and 10 per cent lymphocytes. Urinalysis showed a few pus and red blood cells. Flat roentgenographic abdominal examination was negative.

With a preoperative diagnosis of perforated peptic ulcer, he was taken to surgery. Under spinal anesthesia an upper right rectus incision was made. As soon as the peritoneum was opened large quantities of amber fluid, containing fibrinous flecks, escaped. Careful examination of the stomach from the cardia to the second portion of duodenum failed to show an ulcer or perforation. The lesser peritoneal cavity was explored through gastrocolic omentum, and no perforation could be found. Amber fluid oozed intermittently from many areas, so that tracing the source was difficult. From the duodenojejunal angle, for the first 30 centimeters of jejunum loops were adherent by old fibrous adhesions. This portion of the bowel showed thickened walls, but there was no evidence of regional ulceration until about 35 centimeters from the duodenojejunal angle, where a fresh perforation, $1\frac{1}{2}$ centimeters in diameter, was seen. Bile-stained jejunal contents were escaping from the perforation. The margins of the area were excised and the perforation closed with two layers of intestinal chromic catgut and reinforced interrupted sutures at the angles. Resection of the bowel was inadvisable; so that an entero-anastomosis was made between the proximal jejunum and an area a few centimeters distal to the perforation. The anastomosis was made in the usual manner (using two rows of continuous intestinal chromic catgut sutures, reinforcing with interrupted serosal silk sutures), and the opening readily admitted two fingers. Examination of the rest of the small bowel was negative. The vermiform appendix was small and fibrous. The wound was closed in the usual manner, and reinforced with through-and-through silkworm-gut sutures.

Report on Tissue.

The specimen was examined by Dr. Alvin J. Cox, who described it as follows:

The gross specimen was an oval bit of intestinal wall measuring 9 by 4 millimeters. This was covered on one surface by granular mucosa, which showed no gross abnormalities.

Histologic Examination.—Sections showed jejunal mucosa overlying a piece of edematous muscularis. Both exhibited moderate irregular infiltration of polymorphonuclear leukocytes. At one edge of the section the mucosa showed a heavier leukocytic infiltration and adjoined a

zone of necrotic tissue, heavily infiltrated by leukocytes, and the subserous tissue was edematous with similar leukocytic infiltration. Several small, thin-walled vessels were distended by collections of leukocytes.

The diagnosis was: (1) Ulcer, jejunum, acute. (2) Peritonitis, acute, jejunum.

Progress.

After the first two days of critical illness the patient improved remarkably. On the eighth postoperative day, the wound was opened superficially, pus evacuated, and on culture grew nonhemolytic *Staphylococcus aureus*. Progress was otherwise uneventful, and he was dismissed from the hospital on the sixteenth postoperative day and he has been in excellent health. The wound has healed well.

The final diagnosis was: (1) Ulcer, jejunum, acute. (2) Perforation, acute; ulcer, jejunum.

COMMENT

We believe that an ulcerative lesion of the jejunum is rare, particularly with no previous history of abdominal disease. In this instance there was anatomic evidence of previous, old, serosal disease of the jejunum, if one is to so interpret the serosal fibrous adhesions on the proximal jejunum. However, at no time was our patient symptomatically aware of any intestinal disease.

Search through the literature has failed to find a similar case. The manner in which the perforation was undoubtedly precipitated—namely, excessive lifting—is very commonly encountered in peptic ulcer, and could reasonably occur with ulcerative disease elsewhere in the digestive tract. There are numerous instances in the literature of rupture of the jejunum and ileum, but not on the basis of a previously existing acute ulcer.

In closing, we should like to call attention to this rare cause of acute abdominal disease, simulating acutely perforated peptic ulcer.

261 Hamilton Avenue.

HIPPOCRATES' APHORISMS*

By M. SCHOLTZ, M. D.

Arcadia

SECTION THREE (Continued)

21. In summer a run of chronic tertian fevers, Ophthalmias, vomiting and diarrheas start; Pains of the ears, sudamina and ulcers of the mouth, Withal mortification of the private parts.
22. In fall fits, asthma, ileus and quartan fevers, Melancholy and mania, big spleen; Dysentery, sciatica and dropsy, And quinsy, strangury and phtisis are oft seen.
23. In winter, most prevail coughs and coryzae, Sore throat and pains of the loins and chest; Oft pleurisy, pneumonia, while many're By headaches, dizziness, and strokes distressed.
24. Infants and younger children are inclined To vomiting, coughs, aphtae, running ears, Sore mouths, inflammations of the navel, Insomnia and, oft, nocturnal fears.

* For other aphorisms, see CALIFORNIA AND WESTERN MEDICINE, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85.

25. Pending dentition one may often see,
Especially when canine teeth are cut
in fat and constipated children: fevers,
Convulsions, itchy gums, and diarrhea.
26. Older children are prone to swelling of the
glands,
Infections of the tonsils, scrofula and stones,
Scoliosis of the spine, asthma, and round
worms,
And, oft, tuberculosis of the bones.
27. Still older children and those approaching
manhood
Are prone to the above-cited complaints;
Withal to nose bleedings, chronic fevers and
like taints.
28. Most crises in young people fall in forty days,
In seven months or years, or time of puberty.
An ailment that persists beyond this age
Is likely to become a chronic malady.
29. Those who, past youth
Are subject to
Fits, phthisis, spitting blood
And other ailments, too.
30. Mature persons are prone to asthma, diarrhea,
Phrenitis, cholera, and pleurisy;
Dysentery, pneumonia, and fevers,
Withal to hemorrhoids and lethargy.
31. The old are heirs to dyspnea, catarrhs,
Dysuria, joint pains, nephritis and strokes,
Cachexia, pruritus and cataracts;
Withal discharges of the bowels, nose and
eyes,
Insomnia, and eye and ear impairments.

* * *

SECTION FOUR

1. If it's indicated, pregnant women
From the fourth to the seventh month can
well be purged;
But in the first and last terms of gestation
Strong cleansing is not safe, and should be
never urged.
2. While purging, drain such matters from the
system,
As drain themselves for the body's benefit;
All other stuff, which has no cleansing value,
Should be retained, as harmful to emit.
3. Removal of the stuff of morbid nature,
Which calls for purging, is well borne and
good;
But purging of the stuff which is not morbid
Is weakening, and should be well eschewed.
4. In summer, upward purging
One should prefer;
In winter, purging downward,
One should spur.
5. In dog-days season,
And the time close to it,
Forbear strong purging
And—don't do it!
6. For slender people,
Whose stomachs easy turn,
Upward purging, barring winter,
Is of great concern.
7. All persons moderately fat,
And difficult to retch,
Ought to be purged downward
During the summer stretch.
8. An upward purging in a man
Suffering from phthisis
May easily precipitate
An acute and dangerous crisis.
9. The melancholic sick should be
Purged downward abundantly.
10. In acute illness, if inside matters
Press for an emission,
Purge sick at once, or else you may
Bring on a grave condition.
11. When pains about the loins
And navel are not cleared
By purging, then tympanitis
May commonly be feared.
12. An upward purge of persons
Whose bowels are inflamed
In winter time, is a mistake
For which one might be blamed.
13. The sick upon whom hellebore
Acts hard, with food and rest,
Should moisten well their system
Ere they the drug ingest.
14. The one who takes a drought of hellebore
Should move about and avoid repose;
A rough sea voyage can well prove this point:
It stirs the system up and makes one in-
disposed.
15. To speed up hellebore effect, and make it
stronger,
The sick must move about and keep himself
in action.
The opposite state: indolence and rest
Slow down and impede this potent drug's
reaction.

413 Longden Avenue.

There is no evidence to substantiate the impression that the milk-producing ability of women decreases with age, *Hygeia, The Health Magazine* declares. If the prospective mother can adjust her mental environment and decide that she is going to nurse her baby, she probably will in spite of her age.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HARRY H. WILSON.....President
HENRY S. ROGERS.....President-Elect
LOWELL S. GOIN.....Speaker
PHILIP K. GILMAN.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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PLANKS IN THE PARTY PLATFORMS*

(Major planks of prime interest to the medical profession as presented at the Republican and the Democratic national conventions.)

Republican‡

Relief

"We shall remove waste, discrimination, and politics from relief—through administration by the States with Federal grants-in-aid on a fair and nonpolitical basis, thus giving the man and woman on relief a larger share of the funds appropriated."

Social Security

"We favor the extension of necessary old age benefits on an ear-marked pay-as-you-go basis to the extent that the revenues raised for this purpose will permit. We favor the extension of the unemployment compensation provisions of the Social Security Act, wherever practicable, to those groups and classes not now included. For such groups as may thus be covered we favor a system of unemployment compensation with experience rating provisions, aimed at protecting the worker in the regularity of his employment and providing adequate compensation for reasonable periods when that regularity of employment is interrupted. The administration should be left with the States with a minimum of Federal control."

† For complete roster of officers, see advertising pages 2, 4, and 6.

* From the *Providence Medical News*.

‡ For reproduction of a letter from Candidate Willkie, in regard to socialized medicine, see in this issue, on page 133.

Monopoly

"Since the passage of the Sherman Anti-Trust Act by the Republican party, we have consistently fought to preserve free competition with regulation to prevent abuse. New Deal policy fosters government monopoly, restricts production, and fixes prices. We shall enforce antitrust legislation without prejudice or discrimination. We condemn the use or threatened use of criminal indictments to obtain through consent decrees objectives not contemplated by law."

1 1 1

Democrat

Unemployment

"We are opposed to vesting in the states and local authorities the control of Federally-financed work relief. We believe that this Republican proposal is a thinly disguised plan to put the unemployed back on the dole."

"We will continue energetically to direct our efforts towards the employment in private industry of all those willing to work, as well as the fullest employment of money and machines. This we pledge as our primary objective."

Social Security

"The Democratic party, which established social security for the nation, is dedicated to its extension. We pledge to make the Social Security Act increasingly effective, by covering millions of persons not now protected under its terms; by strengthening our unemployment insurance system and establishing more adequate and uniform benefits, through the Federal Equalization Fund principle; by progressively extending and increasing the benefits of the old-age and survivors insurance system, including protection of the permanently disabled; and by the early realization of a minimum pension for all who have reached the age of retirement and are not gainfully employed."

Capital and Business

"We have attacked and will continue to attack unbridled concentration of economic power and the exploitation of the consumer and the investor."

"We have attacked the kind of business which levied tribute on all the rest of American business by the extortionate methods of monopoly."

"We have enforced the anti-trust laws more vigorously than at any time in our history, thus affording the maximum protection to the competitive system."

Health

"Good health for all the people is a prime requisite of national preparedness in its broadest sense. We have advanced public health, industrial hygiene and maternal and child care. We are coördinating the health functions of the Federal Government. We pledge to expand these efforts, and to provide more hospitals and health centers and better health protection wherever the need exists, in rural and urban areas, all through the coöperative effort of the Federal, State and local governments, the medical, dental, nursing and other scientific professions, and the voluntary agencies."

**Presidential Candidate Willkie's Views on
Socialized Medicine**

Through the courtesy of *Rocky Mountain Medical Journal*, official publication of the Colorado, Utah and Wyo-

ming State Medical Association, an advance copy of the editorial page reproduced below has been received. It should be of interest in relation to excerpts from the platforms of the Republican and Democratic parties, to be found in this issue on the opposite page.

(COPY)

Rocky Mountain
Colorado
Utah
Wyoming

Medical Journal

SEPTEMBER
1940

♦ ————— Editorial ————— ♦

**No Ifs, No Ands,
No Buts or Howevers!**

BEFORE you read these perhaps unnecessary words, you will have seen and read the accompanying photographic reproduction of a letter that deserves a prominent place in current medical history. Never before in the memory of the Editors of this Journal has either a President of the United States or a candidate for that office issued such an unequivocal statement of his position on a medical policy.

As President of the American Urological Association, Dr. T. Leon Howard of Denver obtained an interview with Mr. Willkie, while the latter was enjoying his pre-campaign vacation in Colorado Springs, in the hope of receiving some encouraging word to take to the Urological Association from the Presidential candidate. Not only was the interview wholly satisfactory to all specialties and groups in the medical profession, but Mr. Willkie at once wrote the letter here reproduced, and gave Dr. Howard full permission to reproduce it in "any way you see fit."

An identical space in the October issue of this Journal will be made available to Mr. Roosevelt should he care to use it, and this will be called to his attention.

The records of 1938 (its "Amendment No. 2" in Colorado, its "Measure

No. 2" in California), and similar attacks upon medicine and public health in other states, should be carefully reviewed by all candidates for public office, from the lowest to the highest. *They may well recall that the medical profession, when genuinely aroused, wields political power whose limit has yet to be defined.*

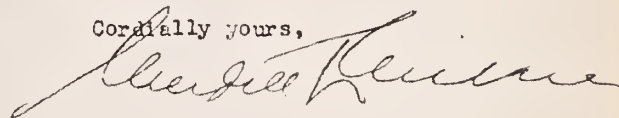
WENDELL L. WILLKIE
109 EAST 42ND STREET
NEW YORK CITY

Colorado Springs
August 7, 1940

My dear Doctor -

You have asked my views on socialized medicine. I am against it. You can quote me any place on this.

Cordially yours,



Dr. T. Leon Howard
Denver, Colorado.

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

American Medical Association Preparedness Committee Functions Outlined

Organizational Setup and Activities of National Group, with Names of State Chairmen, Are Announced

The functions of the National Committee on Medical Preparedness of the American Medical Association, together with those of state chairmen and the names of the latter, are reported in the Medical Preparedness Section of *The Journal* of the Association for August 3. Discussing the national committee, the report says:

"This committee was created by the House of Delegates of the American Medical Association to cooperate with the Advisory Commission on National Defense, the Army and Navy Medical Corps, the United States Public Health Service and all other federal agencies in preparing our nation medically to meet any emergency. The functions of the committee include the following activities:

"1. Meetings devoted to consideration of problems involved in providing medical personnel for military, naval and civilian needs.

"2. Consideration of the provision of medical personnel for physical examination, particularly of young men who are conscripted for medical service, young men assigned to vocational training, persons on relief and those concerned with war industries.

"3. Consideration of economic problems including financial arrangements, leaves of absence, part-time service and other factors associated with civilian medical services.

"4. To maintain contact and to represent the Association in conferences with the surgeon generals of the Army, Navy and Public Health Service and, when necessary, with other governmental agencies.

"5. To maintain contact with the state chairman on medical preparedness.

"6. To encourage and coordinate the activities of the various state chairmen for the National Committee on Medical Preparedness.

"7. To formulate instructions for the guidance of state chairmen.

"8. To review and to approve or disapprove recommendations received from state chairmen.

ACTIVITIES OF STATE CHAIRMEN AND COMMITTEES ON MEDICAL PREPAREDNESS

"The functions of the state chairmen for the State Committee on Medical Preparedness are an extension of the functions initiated and developed by the National Committee. The National Committee on Medical Preparedness includes representatives located in all of the various Army Corps areas and Naval districts. The state chairmen for the Committee on Medical Preparedness maintain contact with other state chairmen in their vicinity through the corps area representative of the national chairman and maintain contact also with the headquarters office of the American Medical Association, which acts as headquarters for the National Committee on Medical Preparedness.

"The functions of a state chairman include the following:

"1. Contact with and coordination of the activities of state, county and district medical societies.

"2. Cooperation with county medical societies in securing completion and return of the questionnaire on personal information.

"3. To establish mechanisms for securing supplementary information to the questionnaire when necessary.

"4. To organize a state committee on medical preparedness to be composed of the president and the secretary of the state medical society, the state chairman for the Committee on Medical Preparedness and ex officio the member of the Committee on Medical Preparedness of the American Medical Association within whose corps area the state is located and such other members as this group may select.

"5. To assist in the organization of county committees on medical preparedness.

"6. To invite local and state health authorities to participate in the work of the program particularly in the matter of civilian health.

"7. To arrange for the dissemination of information on medical preparedness to the groups that are concerned with any particular matter.

"8. To assist in the verification of the qualifications of physicians desired for service in the Army, industry, special physical examinations and other special work necessary for national defense.

"9. To report to the Committee on Medical Preparedness a list of the names of physicians from each county of the state whose services are believed to be necessary for the maintenance of civilian health and who should, in the opinion of the state committee on medical preparedness, be exempt from military service."

* * *

Physicians Respond to American Medical Association Questionnaire for Preparedness Campaign

"Within ten days more than 40,000 physicians returned their questionnaires to the headquarters office of the American Medical Association supplying information to be used in the campaign for medical preparedness," *The Journal of the American Medical Association* for July 27 reports in an editorial. "An especially augmented staff is already at work checking the replies and preparing punch cards which will be used in making the selection of men for functions in preparedness and functions in any national emergency which may develop.

"Every physician should return his questionnaire as soon as possible. Ultimately a punch card will be prepared for each physician in the United States, since it is necessary that every physician be represented in the file. If there is national conscription, physicians will be called as are other citizens of the United States. Great advantage to the physicians, to the Army and Navy Medical Departments, to the United States Public Health Service, and indeed to the country as a whole lies in the development of this material. With the full information once supplied, it will be possible to a considerable extent to fit every physician into work for which he is best suited.

"On July 19 the Committee on Medical Preparedness met in the headquarters office of the American Medical Association with representatives of the United States Army and Navy and Public Health Service. Plans were discussed for utilization of medical personnel. There begin to be indications of the many needs which must be filled in the future. Tremendous expansion of industries associated with the manufacture of munitions and military supplies will require numbers of industrial hygienists, physicians and surgeons far beyond the number now available. Examination of many thousands of men associated with the setting up of recruiting centers, training forces and for similar objectives will again require the services not only of physicians capable of conducting routine examinations but of specialists in every medical field. Particularly important are pathologists, clinical pathologists, roentgenologists (x-ray specialists) and experts in the field of cardiology (study of the heart), tuberculosis and nervous and mental diseases. Finally, it is absolutely necessary to assure continuity of medical service for the civilian population.

"Arrangements were made to utilize state and county

† For complete roster of officers, see advertising pages 2, 4, and 6.

societies in the extension of this work. If a physician fails to return his questionnaire, it will become necessary to ask his colleagues and his state and county medical society to be of service in determining why the physician failed to cooperate and to insure the eventual return of the information.

"At a time when the nation may need the service of every patriotic citizen, the physician owes this obligation to the country and to himself. In a few instances cards and notes have been received from physicians indicating that their sympathies do not lie primarily with the needs of the country. It would be unfortunate indeed if any considerable number of physicians adopted such a point of view. The more promptly the questionnaires are returned, the greater will be the possibility of eventual action. The more accurately the information is supplied the more rapidly will it be codified. It is not only the medical profession that is on trial in this instance but democracy itself."

* * *

American Red Cross Plans Nationwide Enrollment of Voluntary Blood Donors

The American Red Cross, acting at the request of the Surgeon General of the United States Army, recently announced experimental plans for the promotion of a nationwide corps of volunteer blood donors which would become part of the national defense program, when and if needed.

Chairman Norman H. Davis, in announcing the proposed program, declared the plan would be to make available blood plasma to the United States Army Medical Corps in the event of emergency. For the past four years, he said, twelve Red Cross chapters have been furnishing whole blood from volunteers to hospitals for civilian use. The new program will be patterned along similar lines, using plasma instead of whole blood, it was explained.

The American Red Cross also has under consideration a parallel project to furnish voluntary plasma requested by the British Red Cross for the treatment of war victims, Chairman Davis said.

Details of this project are being studied, Mr. Davis said. Two possible plans are being explored, he added. Under the first the American Red Cross would gather voluntary plasma in the United States and fly it to Europe for transfusion purposes. Under the second plan, which Mr. Davis indicated seemed to be more feasible, the American Red Cross would send equipment and technicians to England to gather the plasma on the spot.

For the domestic program, a preliminary study involving 1,300 Red Cross volunteers in four cities throughout the country will be conducted under the direction of a special committee appointed by the National Research Council, Chairman Davis said. . . .

"Preliminary studies," said Dr. William DeKleine, national medical advisor of the Red Cross, "must be made to perfect methods of collecting, storing and administering plasma under conditions comparable to war-time emergency. Blood for this initial study will be furnished by volunteers at the various hospitals where members of the Research Committee are regularly employed. The plasma collected will be stored and used as emergencies arise at these hospitals."

After preliminary investigations have been completed, the Red Cross will then work out with the medical department of the Army plans for enrolling prospective donors in cities throughout the country where collecting centers will be established. In the event of an emergency, the Red Cross could start delivering plasma within ten days after enrollment is completed, Doctor DeKleine said. Blood so collected will be pooled in large sterile containers, to simplify storage, in sufficient quantities to meet the emergency needs for treating the wounded.

Recruiting donors will be conducted by a special chapter blood transfusion committee which will include leading local physicians. The technical phases of the project will be performed by the medical staff of the cooperating hospitals. They will examine the prospective volunteers, make the necessary blood tests as well as doing the actual transfusions.

This blood transfusion project will be another step taken by the Red Cross in its preparedness program for national emergencies. It will function in close cooperation with the medical departments of the military forces, Doctor DeKleine said.

* * *

Alien Registration Division of Immigration and Naturalization Service, Department of Justice

As part of the National Defense program, a nationwide registration of aliens will be conducted from August 27 through December 26, 1940, by the Immigration and Naturalization Service of the Department of Justice. Registration will take place in the post offices of the nation. It is expected that more than 3,500,000 aliens will be registered during the four-month period.

Registration is made compulsory by a specific act of Congress, the Alien Registration Act of 1940, which requires all noncitizens to register during the four-month official registration period. The law requires that all aliens 14 years or older are to be registered and finger-printed. Alien children under 14 years of age will be registered by their parents or guardians. When alien children reach their fourteenth birthday, they will be required to register in person and be finger-printed.

A fine of \$1,000 and imprisonment of six months is prescribed by the Alien Registration Act for failure to register, for refusal to be finger-printed, or for making registration statements known to be false. . . .

Finger-printing of aliens carries no stigma whatsoever. Thousands of citizens are voluntarily finger-printed every year. Members of the United States Army and Navy are all finger-printed, as are many Government workers. In recent years, many hospitals have established the practice of taking footprints of newly born babies. Because finger-printing is the only infallible method of accurate identification, the United States Government has adopted it as part of its registration program.

CALIFORNIA STATE COUNCIL OF DEFENSE

California Adjutant General's Plans for Medical Service Registration and Examination

A program for speedy enrollment of California youths into military service in event Congress adopts a national conscription bill was completed today at Watsonville, where National Guard units are training.

It was worked out under the direction of Captain K. L. Leitch, of the staff of Adj. Gen. Middelstaedt, assisted by twenty enlisted men of the 250th Coast Artillery, California National Guard and by nine commissioned officers.

The program, as announced by Captain Leitch, called for a one-day registration of all youths between 21 and 30 years of age at regular voting precincts in the same manner as registration for an election. The plan could be effective within ten or twelve days, it was said. Designated boards would handle the registration and each registrant would receive a registration number.

As the next step 283 local boards would be set up within the State to classify the registrants. San Francisco would have twenty-seven such boards, probably would be called on to supply 2,000 men in the first draft.

Each draft board would consist of three or more members. Each would have the power within its specified area to determine whether registrants are eligible for enlistment or are to be exempted because of physical handicaps, dependents or other reasons.

These boards would be allocated on the basis of one board for every 30,000 persons in the State. Los Angeles County, having the largest population in the State, would have 107 boards.

Thirty advisors, one for each 1,000 persons in the districts, would be assigned to each board to assist registrants in filling out 15-page questionnaires. In addition each board would have one examining physician and one Government appeal agent. The agent's duty would be to check the action of his local board.

The program also provided for courts of appeal and medical advisory boards.

The plan called for nineteen courts of appeal of five members each. Registrants may appear before such boards and have their cases reviewed. (Note: Changed later to twenty courts of appeal.)

There also would be nineteen medical advisory boards to determine whether physical handicap claims are justified. Those assigned to the advisory boards would be experts in various lines of medicine.

The State would be divided into four separate districts in carrying out the plan.

District 1 would be the Sacramento area consisting of twenty-eight northern counties and forty local boards; District 2, the San Francisco area of ten counties and sixty-eight boards; District 3, the Fresno area of twelve counties and twenty-one boards; and District 4, the Los Angeles area of eight counties and 120 boards.

When registration and classification have been completed and those eligible for enlistment determined, those to be drafted would be selected by lot as provided in the bill now before Congress.

The congressional measure provides penalties for those within the specified age group who fail to register.

The program was contingent on congressional enactment of the conscription bill now before it.—San Francisco *News*, August 1, 1940.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Preparation for a strenuous program of public relations during the coming ten months occupied the Committee on Public Health Education during the last month.

Numerous details of the motion picture scenario contest were decided and necessary printing in connection with the contest was obtained. Consent of the Post Office Department to use the mails for a contest in which prizes are offered was necessary and was obtained. Announcement of the contest was sent to newspapers and advertised in trade publications in Hollywood, where a concentration of writing talent was reached. The contest, however, is open to anyone in California.

Preparations for the conclusion of the junior college—high school essay contest and selection of judges progressed. A directory of leaders in the evening high school

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Goin, Los Angeles; Junius B. Harris, Sacramento; Harry H. Wilson (ex officio), Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUcker 2312), or 244 Kearny Street, San Francisco (telephone YUkon 2212).

adult education forum throughout the State was secured, in order that our speakers' bureaus will be enabled to make speaking engagements before these groups.

Plans were perfected to increase activity in the speakers' bureaus following the close of the vacation season and an extension of the radio broadcasting program, such as that now in effect under the auspices of the Sonoma County Medical Society, will be actively pursued.

Last, but not least, much preparatory work was done on the Basic Science Initiative. Legal aspects were ascertained through the Legal Department and the cost of printing the petitions and other necessary information secured. The plan for circulation of petitions will be announced soon.—R. M.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Eighth District Postgraduate Conference, Tahoe Tavern, August 24-25, 1940*

More than fifty physicians attended the Postgraduate Conference of the Eighth Councilor District, held at Tahoe Tavern on August 24-25.

The program was carried through in excellent fashion, the guest speaker and other addresses, on topics concerned with scientific and organized medicine, all measuring up to the best standards. The arrangement of scientific and social features was in proper balance and received the hearty approval of all who were in attendance. Much credit is due the Local Committee of Arrangements, working under the chairmanship of Dr. Frank A. MacDonald.

State President Harry H. Wilson of Los Angeles on Sunday gave a particularly interesting address.

The Woman's Auxiliary held one separate and one joint meeting, Mrs. A. E. Anderson of Fresno, president of the State Woman's Auxiliary, being among those who took part in the proceedings.

Program of the conference follows:

PROGRAM

Saturday, August 24

a.m.—Registration.

12:00 noon—Luncheon.

FIRST SCIENTIFIC MEETING

1:00 p.m.—Neuralgias of the Face and Neck—Frederick L. Reichert, M. D., Professor of Surgery, Stanford University School of Medicine.

2:00 p.m.—Treatment of Nephritis: Theory—Thomas Addis, M. D., Professor of Medicine, Stanford University School of Medicine.

3:00 p.m.—Recent Advances in Pre- and Postoperative Care of Surgical Patients—Leon Goldman, M. D., Assistant Professor of Surgery, University of California School of Medicine.

4:00 p.m.—The Practical Aspects of Modern Pharmacology—Chauncey Leake, Ph. D., Professor of Pharmacology, University of California.

7:00 p.m.—Banquet—Joint meeting with the Woman's Auxiliary.

Toastmaster—Robert Peers, M. D., Colfax, Past-President of the California Medical Association.

Guest Speaker—Mr. Ben Allen, Palo Alto, California, Associated Press correspondent in London during World War I. Subject—"War-Time Censorship."

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

* For other comment, see page 107.

9:00 p.m.—Dancing in the Casino. Moving pictures. Bridge in the Lounge. Refreshments. Trip to Cal-Neva.

Sunday, August 25

SECOND SCIENTIFIC MEETING

- 9:00 a.m.—Management of Patients with Biliary Tract Disease—Leon Goldman, M. D., Assistant Professor of Surgery, University of California School of Medicine.
- 10:00 a.m.—The Significance of Circulatory Disturbances of the Extremities—Frederick L. Reichert, M. D., Professor of Surgery, Stanford University School of Medicine.
- 11:00 a.m.—Vitamins and Endocrines—Chauncey Leake, Ph. D., Professor of Pharmacology, University of California.
- 12:00 noon—Treatment of Nephritis: Practical—Thomas Addis, M. D., Professor of Medicine, Stanford University School of Medicine.
- 1:00 p.m.—Luncheon—Organization meeting with the Woman's Auxiliary.
Chairman—Dr. Frank A. MacDonald, Councilor, Eighth District.
Speakers—
Harry H. Wilson, M. D., President of the California Medical Association. Subject—Topic to be announced.
George H. Kress, M. D., Secretary of the California Medical Association. Subject—"Some Problems of Organized Medicine."
Mr. Ben H. Read, Executive Secretary, Public Health League of California. Subject—"Medical Legislation."
Mr. Ross Marshall, Public Relations Counsel, California Medical Association Committee on Public Health Education. Subject—"Activities of the Committee on Public Health Education."

* * *

Six Western States Taking Part in Pediatric and Obstetric Program

A long-term educational program to insure better care for mothers and babies in six western states was announced recently by Dr. Amos U. Christie, associate professor of pediatrics at the University of California Medical School.

The program, which will make the Medical School the center of all postgraduate education in pediatrics and obstetrics for the six states, will be under the direction of Doctor Christie.

Financed by funds from the participating states, from the United States Children's Bureau and from the Rosenberg Foundation, the program will provide an opportunity for practicing physicians to come to the Medical School for refresher courses in pediatrics and obstetrics, thus enabling them to take advantage in their practice of the newest medical advances in these fields. The program is part of a plan for postgraduate education promulgated by the California Medical Association. Selected physicians from each state will attend the courses. Their transportation and tuition will be paid by their home states.

In addition, a pediatric circuit rider will be appointed to travel through the western states for consultations with individual physicians, district medical societies and other interested groups on problems involving the care of young children.

The emphasis of the work will be placed on "keeping the well baby well," Doctor Christie said, and on preventive

pediatrics in general. This is in line with present-day practice in which "well baby clinics" play an important part.

States participating are California, Nevada, Utah, Idaho, New Mexico, and Arizona.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Educator Scores Two Billion Dollar U. S. Sickness Bill

The two men who will be candidates for President of the United States in 1980 are now probably youngsters in the elementary or early high school grades, and as such should be the beneficiaries of a public health system that guarantees them and their generation a healthy adulthood. Whether future Presidents and all Americans of their generation are to be strong, healthy, and courageous men depends upon the kind of health instruction and conditions which surround them today, believes Dr. Ira Vaughan Hiscock, professor of public health at Yale University and member of the 1940 Summer Session staff on the Los Angeles campus of the University of California.

"The greatest asset of any community is the life and health of its citizens. Men in public life today know that much of the tremendous economic loss resulting from injuries, sickness and death would be preventable if available knowledge were more generally understood and applied. While some progress has been made, especially during the past decade, it is still estimated that sickness and premature death in the United States involve a direct cost of more than two billion dollars annually for medical services. Besides this, there is a loss of 2 per cent in useful industrial or commercial productivity. Naturally, the taxpayers bear that cost and thus have a tremendous stake in public health. Unfortunately, it would seem that all taxpayers are certainly not getting the public health services to which their contribution to the general welfare would seem to entitle them."

* * *

Acute Diseases Claiming Fewer Victims*

The striking improvement in mortality which our people have been experiencing since the beginning of the century results almost entirely from substantial reductions in the death rates from the acute and infectious diseases. The childhood ages have been chiefly benefited. On the other hand, most of the chronic diseases, which have their greatest incidence in midlife and old age, have shown little or no improvement, and in some cases there have been actual increases in their mortality rates. Of the chronic diseases, tuberculosis is the only one of importance that has shown any marked improvement. As a result of these changes, and also as a result of the mounting proportion of older persons in the population, the chronic diseases have grown rapidly in importance, and now predominate, by far, in our total mortality picture.

An interesting aspect of this shift is revealed by a comparison of the chances, at birth, of eventually dying from acute or chronic disease, according to conditions prevalent in the general population of the United States in a recent year, 1937, with those found in 1920 and in 1901. . . .

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

* From the Statistical Bulletin, Metropolitan Life Insurance Company, July, 1940.

Practically one-third of the children born at the beginning of the century would eventually have died from some acute condition, if mortality conditions then prevailing had continued without change. Twenty years later the corresponding chances were somewhat more than one in four, and, with the favorable situation prevailing in recent times, only one-sixth of the newly born will eventually die from an acute disease. In these changes we have outstanding evidence of the beneficial effects resulting from progress in the control of typhoid fever, diphtheria, pneumonia, and diarrhea and enteritis, to mention only a few of the most typical acute conditions.

Since eventual death is a certainty, it is inevitable that the decreasing chances of dying from acute disease should be complemented by increasing chances of dying from chronic disease, the deaths from external violence and from causes not classified being too few to influence the picture materially. According to mortality conditions at the beginning of the century, every other newly born child would have died of chronic disease; in the present situation, chronic disease will ultimately claim about three out of every four.

A fact calling for notice is the marked increase during the period 1920 to 1937 in the chances of eventual death from external violence. The odds against males are far greater than those against females, the chances of death by external violence being 1 in 10 and 1 in 20, respectively.

Without any remission in our efforts to cope with acute disease, the facts here related give emphasis to the need for a program of campaign against chronic disease. If the future should bring success in this field commensurate with that of the past in the acute diseases, the results for human life might be almost spectacular.

C. M. A. CANCER COMMISSION†

During the last few years the Cancer Commission of the California Medical Association has sponsored study conferences at annual session meetings and at other times. Attention of members is called to the letter which follows. Additional information will be sent on request to Otto Pflueger, M. D., 384 Post Street, San Francisco.

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(COPY)

CANCER COMMISSION PATHOLOGICAL CONFERENCE

Dear Doctor:

The next Microscopic Conference, sponsored by the Cancer Commission, will be held in Los Angeles, December 1. The meeting will take place in Room 272, Hall of Science at the University of Southern California, University Avenue and Thirty-sixth Street Place. It is desired, as in the past, that individuals send in sample slides and a case history for the committee's perusal as soon as possible, the committee consisting of Doctors Budd, Hall and Foord.

If the case is accepted for presentation, the committee will notify you and ask that you make up a set of sixty slides and case histories for distribution. These slides and case histories must be sent to Doctor Pflueger, care of California Medical Association, 450 Sutter Street, San Francisco, before November 15, so that boxes may be set up and sent to those men who send in reservations for the meeting. It is important that this deadline be complied with in order that the material can be promptly sent out.

Kindly send your preliminary history and slides to the chairman of the committee, Dr. John W. Budd, 1407 South Hope Street, Los Angeles. He will notify you of the acceptance of your cases. It is necessary that you bring your own microscope. Please make reservations for the conference by returning the slip below to Dr. Otto Pflueger, 384 Post Street, San Francisco, California.

Very truly yours,

OTTO H. PFLUEGER, M. D., Secretary.

† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising section (bottom of the second column).

CALIFORNIA PHYSICIANS' SERVICE†

California Physicians' Service beneficiary memberships during the month of August totaled 16,650.

Among groups enrolled during August are the following: Dixon Hardware; Capwell, Sullivan and Furth; Community Chest Agencies, Oakland; Poultry Producers of Central California; United Parcel Service, East Bay; Santa Barbara Public Library; Don Baxter, Inc.; Hollywood *Citizen-News*; Stansfield and McKnight, Lindsay; WPA Nutrition Project; Bureau of Agricultural Economics, U. S. Department of Agriculture; Coastates Products, Inc.; International Silver Company; Pacific Gas & Electric Company, certain departments; Bank of America, Berkeley; Northwestern Mutual Life Insurance Company; California Bankers' Association, employees; Brea-Olinda Union High School; Farm Security Administration, Central Office and Visalia District; Agricultural Workers Health and Medical Association; Contra Costa County Employees; H. G. Capwell Company; Wilshire Medical Building; Merchants Express Corporation; St. Francis Hotel Beauty Salon; West Coast Carbon and Ribbon Company; Rubidoux Motor Company; California Newspaper Publishers Association; Sidney Garfinkel Advertising Agency; Joseph A. Krasne; Continental Insurance Company; Graysons Shops, Incorporated, and Leon Livingston Advertising Agency.

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The development of a basis for gathering statistical data that would provide necessary and interesting information at a minimum of expense for accumulation has required a considerable amount of work. Detail for subsequent months is now being worked out, but complete information for the month of April is reviewed herewith.

During the month of April there were approximately 10,725 beneficiary members. Of this number 1,485 required medical care during the month, which was rendered by 1,073 professional members. Some patients required treatment from more than one doctor, so that there were 1,685 cases treated. The distribution of patients by doctors was as follows:

731 doctors saw	1 patient each
159 doctors saw	2 patients each
75 doctors saw	3 patients each
33 doctors saw	4 patients each
24 doctors saw	5 patients each
17 doctors saw	6 patients each
9 doctors saw	7 patients each
4 doctors saw	8 patients each
1 doctor saw	10 patients

The total number of members receiving medical care during the month represented 13.8 per cent of the total membership.

There were 8,971 units of service rendered, with a total of \$11,214.50 being paid to doctors, which represents an average of \$10.45 per professional member.

There were 5,097 professional members in the State and the 1,073 who saw patients represent 21 per cent of the total professional membership.

It is interesting to note that 25 per cent of all cases were treated for respiratory infections, for which 20 per cent of

† Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. Alson Kilgore, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

the total units were expended; that 13½ per cent of all cases were treated for eye and ear conditions (of which 60 per cent were refractions), for which 9.6 per cent of the total units were expended; and that 11 per cent of all cases were treated for skin conditions, for which 9.5 per cent of the total units were expended. In this particular month's experience a large portion of the cases required only short term treatments. Fifty per cent of the total cases treated required care involving less than four units of service. Ninety per cent of the total cases treated required care involving less than ten units of service.

COUNTY SOCIETIES†

PLACER COUNTY

The Placer County Medical Society held a dinner meeting on July 27 at the Freeman Hotel, Auburn, with the president, William M. Miller, M. D., presiding. Fifteen members of the Society were present and there were the following visitors:

Hon. Jerrold L. Seawell of Roseville, president pro tem. of the State Senate; Hon. Allen G. Thurman of Colfax, assemblyman from the Sixth District; J. B. Harris, M. D., of Sacramento, chairman of the Committee on Public Policy and Legislation; W. J. Lynch, M. D., of Weimar; A. W. McArthur, M. D., of Lincoln; Mrs. Harold Karo and Mrs. H. N. March of Grass Valley.

The secretary read the application of Oscar F. Lang, M. D., of Grass Valley, for membership in the Placer County Medical Society, and, on motion made and seconded, Doctor Lang was elected to membership.

A letter from Frank A. MacDonald, M. D., Councilor for the Eighth District, was read concerning a postgraduate course for physicians of the Eighth District to be held at Tahoe Tavern on August 24 and 25. The secretary was instructed to notify Doctor MacDonald that he would receive 100 per cent coöperation.

A letter from Dr. John H. Napier, Jr., district school superintendent, was read. Doctor Napier asked for help of the members of our Society in the physical examination of students of the Placer Union High School and of the Junior College. The secretary was instructed to notify Doctor Napier that Dr. Monica Stoy Briner and Dr. W. P. Lynch of Weimar would assist, as would also Dr. Paul D. Barnes of Loomis. Doctor Thoren reported that possibly one or two other members of her staff might assist.

The secretary read copies of letters from Dr. J. B. Harris, chairman of the Committee on Public Policy and Legislation, which had been sent by him to the Honorable Allen G. Thurman, assemblyman of the Sixth District, and to the Honorable Jerrold L. Seawell, president pro tem. of the Senate. These letters called attention to the support which each of these men had given to the medical profession in the interests of public health. Assemblyman Thurman and Senator Seawell, being called upon, responded.

President Miller then presented Dr. J. B. Harris of Sacramento, former president of the California Medical Association. Doctor Harris entertained the members of the Society and the guests with a lecture on "Pioneer Physicians of California." This address was illustrated by means of lantern slides commencing with the picture of Doctor Logan, the first president of the California Department of Public Health. The California Department of Public Health was the second state department of health in the U. S. A., the first being that of Massachusetts, which antedated California by six months. Doctor Logan had

been corresponding with Doctor Shattuck of Boston for a considerable period of time urging the formation of just such an organization. Undoubtedly, the formation of the Massachusetts State Board of Health by Doctor Shattuck was the result of this correspondence. Doctor Harris also showed photographs of the members of the first State Board of Health and of many of the pioneer physicians and surgeons of California and also of early-day hospitals, hospital staffs and nursing staffs. These, together with Doctor Harris' humorous running comment, made a most enjoyable as well as instructive meeting.

ROBERT A. PEERS, *Secretary*.



YUBA-SUTTER-COLUSA COUNTY

Meeting of the Yuba-Sutter-Colusa County Medical Society at Hotel Marysville, Tuesday noon at a luncheon, August 6, 1940.

President Miller called the meeting to order. He made mention of the fact that it had been called to his attention that a marker had never been placed on Doctor Peery's grave, who was buried in the Sutter Cemetery, and on motion made and seconded, it was voted that the president appoint a committee to investigate and determine what should be done.

A letter was received from Doctor Barr of Yuba City in which he expressed appreciation to the society for remembering his recent birthday anniversary.

President Miller read the letter from Doctor Dukes of the California State Council of Defense in regard to medical preparedness and the action requested was taken.

A letter from Councilor MacDonald called our attention to the two-day Postgraduate Session at Lake Tahoe Tavern, August 24 and 25. Literature from National Physicians' Committee was presented, distributed and discussed.

Miss Helen Andersen of the local SRA office was introduced and discussed employability and examinations, and hypothetical cases were presented. Discussion was participated in by most of the group. It was finally agreed between Miss Andersen and members of the society that:

1. Employability examinations should henceforth not be made by the resident of the County Hospital.
2. That following an illness at the hospital, said client would be referred to a panel physician for employability examination.
3. That where there is any question regarding employability that a report of previous examination of the client accompany request for a further employability examination, and especially if said client is being referred to a second physician examination.
4. That where there is a discrepancy of opinion between the SRA and County Welfare, that there be a reexamination with the SRA panel examiner acting in consultation.

LEON M. SWIFT, *Secretary*.

CHANGES IN MEMBERSHIP

New Members (30)

Alameda County (16)

Arthur L. Abbett, *Oakland*
John C. Bartlett, *Berkeley*
Martin Benzinger, *Oakland*
Frederick E. Blume, *Oakland*
Lemuel P. Borden, *San Jose*
John P. Degnan, *Livermore*
John L. Gompertz, *Oakland*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Howard F. Graham, *Oakland*
 Thelma J. Lovett-Jennings, *Berkeley*
 Henry G. Mankin, *Berkeley*
 Philip Matzinger, *Oakland*
 Lowell E. McAlear, *Berkeley*
 Eleanor R. Nelson, *Piedmont*
 Beryl B. Seike, *Piedmont*
 Jasper J. Stallone, *Albany*
 Michael Wachtel, *Alameda*

Orange County (1)

Ralph M. Crumrine, *Santa Ana*

Placer County (1)

O. F. Lang, *Grass Valley*

Riverside County (2)

Grover Hewitt Poos, *Palm Springs*
 George Harvey Rue, *Riverside*

San Diego County (2)

James I. Knott, *San Diego*
 Tim V. Richey, *San Diego*

San Francisco County (7)

Boston M. Day, *San Francisco*
 Marlow B. Harrison, *San Francisco*
 Rolla B. Hess, *San Francisco*
 Fred H. Lawrence, *San Francisco*
 Leon E. Mermod, *San Francisco*
 Gregory Smith, *San Francisco*
 Seymour P. Smith, *San Francisco*

Santa Clara County (1)

Lydia L. Verbarb, *San Jose*

Transfers (1)

John K. Odegard, from San Francisco County to Placer County.

In Memoriam

Brown, Adelaide. Died at San Francisco, July 29, 1940, age 72. Graduate of Cooper Medical College, San Francisco, 1891, and licensed in California the same year. Doctor Brown was a retired member of San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Cole, William. Died at Compton, July 9, 1940, age 48. Graduate of the University of Manitoba Faculty of Medicine, Winnipeg, Canada, 1913. Licensed in California in 1921. Doctor Cole was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

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MacDonald, Everett A. Died at Beverly Hills, August 3, 1940, age 69. Graduate of Medical College of Ohio, Cincinnati, 1895. Licensed in California in 1900. Doctor MacDonald was a retired member of the Los Angeles County Medical Association, and the California Medical Association, and a Fellow of the American Medical Association.

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Miller, Robert Warren. Died at Los Angeles, August 6, 1940, age 90. Graduate of the College of Physicians and Surgeons, Keokuk, Iowa, 1876. Licensed in California in 1888. Doctor Miller was a retired member of the Los

Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Thompson, Ernest Eugene. Died at Red Bluff, July 19, 1940, age 64. Graduate of Cooper Medical College, San Francisco, 1900, and licensed in California the same year. Doctor Thompson was a member of the Tehama County Medical Society, the California Medical Association, and the American Medical Association.

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Updegraff, Howard Leighton. Died at Los Angeles, August 8, 1940, age 43. Graduate of the University of Nebraska College of Medicine, Omaha, 1918. Licensed in California in 1928. Doctor Updegraff was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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Worthington, George Barrow. Died at San Diego, August 12, 1940, age 63. Graduate of Cooper Medical College, San Francisco, 1904, and licensed in California the same year. Doctor Worthington was a retired member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES

Howard Leighton Updegraff

1896-1940

Howard Leighton Updegraff passed away at the age of 43 on August 8, 1940. An acute hemorrhagic pancreatitis of unabatable severity brought to a rapid close the life of a physician whose death saddened his patients, friends and conferees.

He was born in Omaha, Nebraska, the son of Dr. Elmer and Catherine Updegraff, educated at Lake Forest Academy, and obtained his B. Sc. in 1917 and his M. D. in 1918 at the University of Nebraska. After serving as house surgeon at Kings County Hospital in New York City from 1919 to 1921 he returned to Omaha to practice surgery, becoming also assistant division surgeon of the Missouri Pacific Railroad 1921-1925. He was a Delta Chi, Phi Rho Sigma and a Presbyterian.

Early he decided on reconstructive surgery as his specialty and after studying with various surgeons to perfect himself he removed to Hollywood in 1928.

He was made an honorary member of the Royal Australasian Medical Society after delivering a paper on Reconstructive Surgery in Australia in 1937. He was a Fellow of the American College of Surgeons, a Fellow of the American Medical Association, a member of the Society of Plastic and Reconstructive Surgery, Past President of the International Medical Society, Associate Editor of the American Journal of Surgery, to which he was a frequent contributor, the latest of his articles to be published in September, 1940. He was a member of the Barlow Society for the Study of the History of Medicine to which he willed his library of incunabula on Plastic Surgery. Doctor Updegraff was an avid bibliophile and owner of the largest collection of books on Plastic Surgery in the United States of America.

He was one of the most loyal and active members of the Hollywood Academy of Medicine. At the time of his death he was Commander in the United States Naval Reserve Medical Corps and had written the Plastic Surgery Manual for use of navy surgeons.

Doctor Updegraff was an active member of the Pan-Pacific Surgical Society which met bi-yearly in Honolulu. He was chairman of the surgical motion picture section and had recently completed "The Making of a Surgical Motion Picture," a masterpiece in color photography.

Besides being a writer and bibliophile, he was an able artist, sculptor and pianist, interested in motion pictures with a wide circle of friends and patients in the motion picture colony, and deeply interested in the home he had recently built in the Outpost District. He was meticulous in every act of his life—he crowded every day so full that his friends must feel that by his own overactivity his allotted seventy years were reduced to forty-three.



Adelaide Brown
1868-1940

On July 29 Dr. Adelaide Brown, for many years a member of the San Francisco County Medical Society, died suddenly at her home of a heart complication following an accident which she had suffered a month previously in the Yosemite Valley.

Born in Napa, California, in 1868, Doctor Brown spent all of her seventy-two years in the atmosphere or actual work of the medical profession. A graduate of Smith College in 1888, and of Cooper Medical College in 1892, she served her internship in the New England Hospital for Women in Boston, and then studied in a number of the leading gynecology clinics in Europe for nearly two years. Following this she returned to California to take up practice with her mother, Dr. Charlotte Blake Brown.

Throughout the whole of her career Doctor Brown was connected with organized efforts to improve public health and preventive measures in medicine, and achieved fame as a humanitarian, physician and scholar. She served as a member of the State Board of Health for sixteen years, to which she was appointed by Governor Johnson. She was one of the organizers of the Milk Commission, and was director of Children's Year in California during the first World War, where more was accomplished than in any other state in the Union except Massachusetts. Every move forward in preventive medicine and public health found her a powerful agent in effective work, and health officials from other counties as well as her own profited from her valuable coöperation and advice.

Although retired from active practice for the last six years, Doctor Brown continued to be actively interested in all organization work for the better distribution of medical care, and in intensive efforts to raise the standards. First and last a great believer in the influence of women, she was followed enthusiastically by women's organizations throughout the State, and our low death rate bears testimony to the results of her efforts. Her unique power for leadership and her forceful personality will be missed by all those who were privileged to work with her or to know her as a friend.

H. M. F. BEHNEMAN, M. D.

The rapid decline in tuberculosis mortality rates has been due mainly to lessening in the incidence of infection. Among those infected, the toll though diminished, is still appalling. Mortality statistics, morbidity reports, autopsy examinations, tuberculin tests and x-ray surveys, indicate that about half of all infected individuals develop clinical tuberculosis, and that from 10 to 20 per cent of them eventually die of the disease. The high risk of disease and death due to infection by the tubercle bacillus justifies increased efforts for its prevention.—Emil Bogen, M. D., *Amer. Rev. of Tuberc.*, August, 1940.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN.....Asst. Chairman on Publicity

Meeting of Board of Directors*

Meeting was held Wednesday, May 8, 1940, at 3:30 p. m. at the Coronado Hotel, Coronado.

1. Roll Call.

All members of the Board were present except Mrs. E. R. Scarboro, corresponding secretary; Councilors Mrs. J. C. McClure, Mrs. E. O. Brown and Mrs. Frank A. Lowe.

2. Business.

a. The President announced the names of the Chairmen of Committees.

b. Officers were requested to study the National Handbook and *The Bulletin*; and to submit to the President a complete outline of their year's work.

c. Basis of award of the Doane Trophy was discussed.

d. Next Board meeting was announced for September in Alameda County.

e. The Nominating Committee is to hold its meeting at the time of the February Board meeting in Fresno.

f. Outstanding bills were ordered paid.

3. Adjournment.

MRS. ROBERT K. CUTTER,
Recording Secretary.

Report on the Eighteenth Annual Session of the Woman's Auxiliary to the American Medical Association‡

By MRS. A. E. ANDERSON, Fresno
*President, Woman's Auxiliary to the California
Medical Association*

REPORT

Dear Auxiliary Members:

The privilege of attending the National Convention of the Woman's Auxiliary to the American Medical Association in New York City extended by you to me was deeply appreciated.

There I met old acquaintances seen last at the convention in San Francisco, and met and exchanged ideas with doctors' wives from east, north, south and west.

These contacts are so very valuable. To talk to delegates and presidents from other states, to absorb their original suggestions, to secure their outlines of projects differing from our undertakings in California is an inspiration of untold worth to one just beginning her year's work as president.

We arrived in New York City on June 9 in time to register at convention headquarters in the foyer of the Grand Ballroom of the Pennsylvania Hotel.

There we were met by an efficient and well-organized group of smiling gracious women who answered all our

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 5867 Whitworth Drive, Los Angeles. Brief reports of county auxiliary meetings will be welcomed by Mrs. Von Hagen and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

* Abstract of Minutes.

‡ An abstract of the report.

questions, registered us and informed us about the excellent program and the delightful entertainment provided for us.

At 4 p. m. a delightful tea was given at Sherry's to the members of the National Board of Directors and honoring the national president, Mrs. Rollo K. Packard. Charles Dwight Reid, M. D., baritone, was presented in a most pleasing program.

The pre-convention board meeting was held Monday morning at 10 o'clock. Many important matters incidental to the smooth functioning of the organization were discussed.

There was a detailed treasurer's report which showed that the finances of the Auxiliary are in a healthy condition. Also the budget for the coming year was presented and accepted.

Monday evening the members of the National Board were guests of the Auxiliary of the Medical Society of the State of New York at a delightful dinner in the Empire Room of the Waldorf-Astoria. Oscar, the famous chef of the Waldorf, welcomed us most graciously during the dinner hour. Later we were privileged to hear the charming lyric soprano, Clare Alcée, of Syracuse, through her friendship with one of our members. Miss Alcée enjoys an enviable reputation not only in this country but also abroad.

The formal opening of the convention took place Tuesday morning at 9 o'clock. Both the president, Mrs. Packard, and the president-elect, Mrs. Holcombe, stressed the thought of "Preparedness" and "Service to Humanity" in their addresses.

Tuesday was given over to the reports of officers and chairmen of standing committees. We adjourned at noon to meet for a luncheon honoring the past presidents. Dr. Rock Sleyster, the president of the American Medical Association, brought us greetings. Dr. Morris Fishbein, editor of the *Journal of the American Medical Association* and *Hygeia*, was the guest speaker.

Doctor Fishbein gravely reported to us what we had surmised from publicity emanating from the American Medical Association meetings and from the newspapers that the chief discussion in the House of Delegates of the American Medical Association centered around Organization for Medical Preparedness. That there were 140,000 physicians in the United States capable of rendering services to the troops in cantonments or for home service. He urged upon the women to feel the deep responsibility of the big job they have in public relations work to educate the public as to what is right in medical service. He made us all feel so keenly the need to be prepared for any national emergency that may arise.

Tuesday afternoon a conference was held. At this time the chairmen of Legislation, Program, Public Relations and Organization gave detailed reports and answered questions.

Wednesday morning's session was again held in the Grand Ballroom. At this time the reports of state presidents were given.

At Wednesday's luncheon, Dr. Nathan Van Etten, the incoming president of the American Medical Association, was the guest speaker. His address was most stimulating and invigorating. As his address contained many original ideas which I shall try to incorporate into your programs of work, at this time I shall not include them in this report, but in my report to your county presidents.

After this stimulating address, Dr. Charles Gordon Heyd, the general chairman of the convention, followed. He relieved the great tension by his witty and humorous remarks.

At the conclusion of the luncheon we again convened to complete the business of the convention.

A resolution was passed to discontinue the reading of the state president's reports. After this, each president will be allowed two minutes to give the highlights of her year's work and will be asked to file her complete report.

Mrs. R. E. Mosiman of Seattle, Washington, was selected for the office of president-elect. You all know her for her outstanding work as chairman of Public Relations.

The installation of officers, conducted by Mrs. James Blake, was the most beautiful and impressive service I have ever seen.

Mrs. Holcombe, our stately and gracious president from Charleston, West Virginia, in her inaugural address asked us to work out our programs incident to the needs of our communities. She selected as her theme for the year, "Service to Humanity."

At the post-convention board meeting, Mrs. Holcombe asked us to attempt to sell to at least one-fourth of our membership the "Bulletin" so that as many as possible will be familiar with the activities of the National.

As it is from the reports of the national chairmen we receive our most helpful suggestions, I will call your attention to some of them.

Organization.—The report of the chairman, Mrs. David Thomas, showed an increase of 2,423 members over last year. California ranked second in increase of membership. The state of Ohio was added to the Auxiliary. California was reported as the best organized state in the West.

Program.—Mrs. Walter Donaldson, chairman, took as her slogan: "To inform others, inform yourself." She stressed the importance of having interesting programs, of having as many members as possible participating. She advised the inclusion of all phases of Auxiliary work in the programs.

Public Relations.—Mrs. R. E. Mosiman emphasized that true Public Relations work concerns itself with the education of the public, not with philanthropic work. She had prepared a chart showing the coöperation of the states in the following projects:

1. With the Department of Public Relations of the medical society.
2. With the State Public Health Department.
3. Promoting interest in national radio programs on health.
4. Promoting interest in Medical Speakers' Bureau.
5. Sponsoring essay contests on health in the public schools.
6. Disseminating literature on health and medical economics.
7. Holding Public Relations meetings for lay groups.
8. Special educational projects: Cancer, Public Welfare, Communicable Diseases, Tuberculosis, National Health Programs.

Hygeia.—Mrs. Eben J. Carey reported an increase in the circulation of *Hygeia*. California ranked seventh. Let us better that record. Mrs. Carey reminded us again that the House of Delegates urges the Woman's Auxiliary to recognize as one of its chief activities the promotion of the distribution of *Hygeia*—the only authentic health magazine published in this country.

Exhibits.—Under the able leadership of Mrs. Ily Beir the exhibits were interesting and instructive. Thirty-seven states were represented. Scrap books, posters and maps told the story not only of the growth of the states but also of the projects undertaken. There was a great demand for California's "Courier" and the supply was soon exhausted.

Legislation.—Mrs. Arthur A. Herold had prepared and had printed a comprehensive survey of pending legislation of interest to the medical profession. Upon request, she will keep us informed.

The social functions of the convention were most carefully planned and executed. Mrs. Carlton F. Potter and her committees deserve the greatest amount of credit for a very successful convention. As New York City has no Auxiliary, the chairmen of these committees had to be selected from towns and cities throughout the great state of New York.

There were many delightful attractions provided for us to choose from. It was possible to take any number of cruises around Manhattan Island, to tour the city, to visit NBC studio, to preview the movie "The Doctor Takes a Wife," to visit Rockefeller Center and many other attractions.

The committee supplemented its many letters to the state officers by a delightful little pamphlet called "Convention Chatter," which was distributed after the opening session.

The attendance at the convention including National Board members, delegates, alternates, members and guests totaled 908. California was represented by three delegates, two visitors and your president.

Again may I thank you for the honor and privilege of representing you there.

Very sincerely yours,

MRS. A. E. ANDERSON, *President.*

**Eighth District, Woman's Auxiliary to the California Medical Association, Tahoe Tavern,
August 24-25, 1940***

PROGRAM

Saturday, August 24

- a.m.—Registration.
12:30 p.m.—Luncheon—Prominent speakers on organization subjects.
2:00 p.m.—Bridge and games on the terrace.
4:00 p.m.—Afternoon tea. Music.
7:00 p.m.—Banquet—Joint meeting with Eighth District, California Medical Association.
Toastmaster—Dr. Robert Peers, Colfax, Past-President of the California Medical Association.
Speaker—Mr. Ben Allen, Palo Alto, Associated Press correspondent in London during the World War. Subject—"War-Time Censorship."
9:00 p.m.—Dancing in the Casino. Moving pictures. Bridge in the Lounge. Trip to Cal-Neva.

Sunday, August 25

- 9:00 a.m.—Breakfast.
10:00 a.m.—Boating trip around Lake Tahoe. Swimming in outdoor pool at the Tavern. Golf on nine-hole golf course. Bridge on the terrace.
1:00 p.m.—Luncheon—Joint meeting with Eighth District, California Medical Association.
Speakers—See under California Medical Association, Eighth District program.

NEVADA STATE MEDICAL ASSOCIATION

C. W. WEST, Reno.....President
H. A. PARADIS, Sparks.....President-Elect
HORACE J. BROWN, Box 698, Reno.....Secretary-Treasurer

The annual meeting will be held at Las Vegas on October 10, 11 and 12.

The Clark County Medical Society members are making arrangements to entertain in royal manner.

They have planned a motor trip on Lake Mead and an inspection of Boulder Dam, starting at 1 p. m., October 10.

A barbecue dinner on the shores of the lake will immediately follow the boat ride.

The scientific session will start Friday, October 11, and the official part of the meeting will end Saturday afternoon, October 12.

* Meeting in conjunction with the Eighth District Post-graduate Conference. See page 136.

There will be a dinner dance on either Friday or Saturday night, which will be announced later.

Arrangements are being made to take the ladies to Charleston Peak on one day of the meeting and other sight-seeing trips are planned.

There will be ten papers, covering subjects of particular interest to the physicians of Nevada by essayists from Salt Lake City, Los Angeles, Oakland and Phoenix, and one or two papers by Nevada men.

At the special request of Clark County members there will be no hotel designated as official headquarters. There are a number of first-class hotels in Las Vegas that are air-conditioned and their rates will appear in a later announcement of the *Nevada Medical Bulletin*.

The Official Call will be mailed about September 20, with the usual return card, and the Chairman of the Committee on Arrangements will be glad to make hotel reservations.

For additional information, address the Association Secretary, H. J. Brown, M. D., Medico-Dental Building, Reno, Nevada.

U. S. Supreme Court Has Not Ruled that Medicine Is a Trade.—"Recently a widely circulated publication has asserted that the Supreme Court of the United States has definitely decided that the practice of medicine is a trade within the meaning of the Sherman Anti-Trust Law of the United States. Such a statement is not correct."

"The facts are as follows: On July 26, 1939, the District Court of the United States for the District of Columbia sustained the demurrer of the defendants to the indictment in this case and dismissed the charge against the defendants. The government appealed this ruling to the United States Court of Appeals for the District of Columbia. On March 4, 1940, the Court of Appeals filed its opinion reversing the decision of the District Court and remanded the case to the District Court for a trial on the merits of indictment. Thereupon the defendants petitioned the Supreme Court of the United States to grant a writ of certiorari to review the decision of the Court of Appeals. The United States filed its brief and argument in opposition to the petition of the defendants for a writ of certiorari and therein asked the Supreme Court of the United States not to review the decision of the Court of Appeals at this time because the government argued that the judgment of the Court of Appeals was not final and the Supreme Court ought not review this case until after a trial was had and all the facts appeared in the record. In its brief the government conceded that the question whether the practice of medicine was a trade was a novel one of sufficient importance for the Supreme Court of the United States to settle but urged that this question be not settled by the Supreme Court of the United States until after a trial of the case, when all the facts would fully appear of record. Apparently the Supreme Court of the United States accepted the argument and suggestion of the government and declined to review the decision of the Court of Appeals at this time.

"The fact that the Supreme Court of the United States declined to review the decision of the Court of Appeals at this time does not mean, as all lawyers know, that the Supreme Court of the United States approved the opinion of the Court of Appeals but means only that for the present the Supreme Court of the United States is satisfied with the action of the Court of Appeals in sending the case back to the District Court for a trial on the merits. If the result of such a trial should be adverse to the defendants, the question whether the practice of medicine is a trade within the meaning of the language used in the Sherman Anti-Trust Law would still be an open question for the Supreme Court of the United States to decide. The Supreme Court of the United States has not yet decided that the practice of medicine in the District of Columbia is a trade within the meaning of the language of the Sherman Anti-Trust Law."

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

American Medical Association, Cleveland, Ohio. (Exact date not decided.)

California Medical Association, Hotel Del Monte, Del Monte, California, May 5-8, 1941.

American College of Physicians, Statler Hotel, Boston, April 21-25, 1941.

American College of Surgeons, Chicago, October 21-25, 1940.

Medical Broadcasts.*

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KTMS	Santa Barbara
KFSD	San Diego	KEX	Portland
KGO	San Francisco	KJR	Seattle
	KGA	Spokane	

† † †

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of September is as follows:

Wednesday, September 4—KECA, 11:15 a. m., The Road of Health.
 Saturday, September 7—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, September 11—KECA, 11:15 a. m., The Road of Health.
 Saturday, September 14—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, September 18—KECA, 11:15 a. m., The Road of Health.
 Saturday, September 21—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, September 25—KECA, 11:15 a. m., The Road of Health.
 Saturday, September 28—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Health Board Posts Filled.—Examiner Bureau, Sacramento, July 29.—Governor Olson today named a University of California and a Stanford University professor to complete unexpired terms on the State Board of Health.

Olson's choices were Dr. Amos Christie, professor of pediatrics at Berkeley, and Dr. Charles Smith of the department of public health and preventive medicine at Stanford.—San Francisco *Examiner*, July 30.

† In the front advertising section of *The Journal of the American Medical Association*, a different roster of national officers and organizations appears each week, each list being printed in revised form about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Pacific Association of Railway Surgeons: Annual Session, Reno, September 20-21.—The thirty-eighth annual session of the Pacific Association of Railway Surgeons will convene this year in the City of Reno, on Friday and Saturday, September 20 and 21.

Headquarters will be at the Riverside Hotel, but scientific meetings will be held in the State Building. A tentative program includes topics of interest and value to the railway surgeon. In addition, a prominent officer in the United States Army will give an address on Military Surgery. Medico-legal aspects of railway work will be given special consideration. Round table conferences will be conducted on subjects of surgical and medical interest.

Federal Grants to Aid in Controlling Gonorrhea and Syphilis.—The forty-eight states, four territories and the District of Columbia have been allotted \$5,672,388 in federal funds to aid in controlling syphilis and gonorrhea during the coming year, Surgeon General Thomas Parran of the United States Public Health Service announced recently.

A special portion of these grants, amounting to \$458,600, has been allotted to the states on the basis of the extent of military and national defense industrial concentrations.

"This special fund," Doctor Parran pointed out, "can be considered only as a first step toward aiding the states to meet the special problems of venereal disease control which arise in connection with concentrations of armed forces and intensification of industrial activities. An increase in the size of the standing army, an extension of the training areas, or the further expansion of defense industries will greatly increase the need for expanded control programs and the necessity for additional funds."

"Venereal disease extracts a very large toll of man-days and efficiency from the armed forces. It is important to note that a large proportion of infections originate in the communities of the Nation before enlistment. The need for adequate control programs in all communities is clear. And it is obvious that the responsibility for prevention of new venereal disease infections among enlisted men lies in the adequacy of the control programs in the towns and cities near areas of military concentration and maneuvers."

Funds made available to the states for the control of the venereal diseases are allotted under provisions of the La Follette-Bulwinkle Venereal Disease Control Act of 1938. In addition to plans for coöperation with the armed forces, considerations in determining allotments include population, extent of the venereal disease problem, and financial needs of the states. Funds allotted on the basis of the population and extent of the problem must be matched by state and local funds.

The remainder of the total appropriation will be used to further research in new methods of treatment and diagnosis of syphilis and gonorrhea, for training of personnel, for coöperation of educational efforts, and for coöperation with the states in planning and administration of the Public Health Service program.

A total of \$6,200,000 was appropriated by the Congress for this fiscal year to aid the states in the control of syphilis and gonorrhea. Last year a total of \$5,000,000 was available.

The American College of Physicians.—The twenty-fifth annual session of the American College of Physicians will be held in Boston, with general headquarters at the Statler Hotel, April 21-25, 1941.

Dr. James D. Bruce of Ann Arbor, Michigan, is president of the College and will have charge of the program of general scientific sessions. Dr. William B. Breed of Boston has been appointed general chairman of the session, and will be in charge of the program of clinics and demonstrations in the hospitals and medical schools and of the program of panel and round table discussions to be conducted at the headquarters.

"Chiggers."—In the summer and early fall when it is necessary to go into fields of tall grass or weeds, or wherever there is heavy undergrowth, the United States Public Health Service suggests the use of flowers of sulfur, applied liberally to the stockings and underclothing as a partial protection against "chiggers."

"As soon as possible after being exposed to chigger mites, it is advantageous to apply a thick lather of soap all over the body surface, and to allow the lather to remain on for ten minutes or longer before washing off. Lather the body well a second time, then rinse thoroughly with clean water," the Public Health Service advises in its bulletin released recently. (Public Health Reports, Vol. 55, No. 29.)

The mites are promptly killed by kerosene or 95 per cent alcohol, but as these liquids may be irritating to some skins, they should be used with caution, according to the Public Health Service.

Contrary to popular belief, the chigger does not burrow into the skin and imbed its entire body. The mite apparently feeds on the upper layer of the skin after this tissue has been dissolved by a substance which the chigger injects into the skin. It is the effect of this substance which causes the intense itching associated with the attack of this annoying mite.

After the chigger has become engorged with food it loosens its hold and falls off.

The chigger in the United States has not been shown to transmit any disease.

Calcium Deficiency Causes Food Waste, Loss of Appetite.—Waste of food energy, subnormal growth and abnormally thin bones are some of the results of calcium deficiency in rats, according to three University of California researchers.

The three, Dr. David M. Greenberg, biochemist at Berkeley, Dr. Max Kleiber of the College of Agriculture at Davis, and Muriel Boelter, graduate student, have published the results of their findings in the last issue of the *Journal of Nutrition*.

In comparison with control animals, fed on normal diets, rats on calcium deficient diets exhibit an abnormally high metabolic rate. Food is burned up so rapidly that the energy released is not efficiently utilized, a large amount being dissipated in the form of heat. Measurements show, according to this report, that calcium deficient animals waste about one quarter of the food energy consumed by normal rats. Part of this, however, may be caused by the passage of unburned food from the body along with normal waste products.

The speed of metabolism may indicate hyperactivity of the thyroid gland which directly influences the metabolic rate, the investigators said.

The skeletons of the deficient animals revealed that calcium lack produced thin bones and short, narrow heads.

Rats on calcium deficient diets also showed a decrease and finally a cessation of growth, brought about mainly by decreased appetite, caused by calcium deficiency.

Laboratory Technicians.—The state convention for the California State Association of Laboratory Technicians will be held in San Francisco, September 28 and 29. All technicians are invited, nonmembers of the state organization being welcome to ask of local chapters as to qualifications for membership. The Los Angeles Chapter meets the last Monday of the month at the Children's Hospital in Hollywood.

The California Association of Medical Technicians is a nonpolitical, nonprofit, state-wide organization having county chapters as units of such state group. It functions with the approval of the state director of laboratories, Dr. W. H. Kellogg, who also directs the state examinations for technicians given twice a year. Examinations cover four fields of laboratory work: bacteriology, serology, biochemistry and parasitology. When an applicant has passed such examination a state license is issued giving such person permission to practice medical laboratory work. A large majority of our licensed technicians are college graduates with excellent backgrounds as good laboratory workers.

Physicians' Bowling League Under Way in Los Angeles.—A movement is on to create a physicians' bowling league in Los Angeles. Interest in the formation of such a league was expressed by Dr. Lewis Wine Bremmerman, who asks that all members who want to help in the formation of bowling teams communicate with him. His address is 1709 West Eighth Street, Los Angeles.

Doctor Bremmerman stated: "The great interest in bowling depends upon the fact that the game makes manifest a keen, competitive action. Everyone tries for that very evasive score of three hundred; those who succeed in this, of course, are few and far between.

"We are now forming a league to be composed only of Doctors of Medicine, members of the Los Angeles County Medical Association, who are interested in this form of sport. It is our hope to have ten teams of five men each from among the physicians of Los Angeles County to begin with. Our object, however, is to develop a state-wide league and then to create a national organization patterned after the American Medical Golf Association, with annual tournaments in the city in which the American Medical Association has its annual meeting. This would bring about much good sport and good fellowship." . . .

Maternal and Child Health Institute Held at U. C. L. A.—Problems dealing with the welfare and health of mothers and children were reviewed in exhaustive fashion at the Institute on Maternal and Child Health which recently convened on the Los Angeles campus of the University of California for a two-day session. Dr. Ira V. Hiscock, University of California Summer Session faculty guest member from Yale University, is presiding at the conference.

A general session convening in the University's Education Building had as chairman Dr. Wilton L. Halverson, Pasadena health officer. Needs in the field of maternal and child health service and the development of maternal and child services on a community basis served as topics of discussion at the morning session. A 2 p. m. session dealt with the maternity care and care of premature and newborn children with Dr. Ellen S. Stadtmuller, of the California Department of Public Health, serving as discussion leader. At a second afternoon conference under the leadership of Dr. Anna Rude, of the Los Angeles County Health Department's Bureau of Child Hygiene, dentistry for children was discussed. Dr. Earle R. Hedrick, vice-president of the University of California, presided at an 8 o'clock evening session at which speakers were Dr. Bertram P. Brown and Dr. Martha Eliot. . . .

A Warning to Local Registrars: Delayed Birth Registration.—The United States Bureau of the Census has issued a warning to state registrars of vital statistics that they will have to guard against a tendency to relax the safeguards protecting the machinery for delayed birth registration. To lower standards undermines the legal status not only of certificates subsequently issued, but of all certificates ever issued by that state. The bureau also states that registrars must guard against fraudulent affidavits submitted in an effort to obtain a delayed birth certificate. Because of the war abroad, it is possible that some individuals here might desire the protection of a citizenship to which they are not entitled. Vigilance is the price of accuracy.

In California, the law requires that a birth certificate be filed within four days after the date of such birth, and unless the certificate is filed within a year from the date of birth, it can not be accepted for filing, making it necessary to petition the superior court of the county in which the birth is alleged to have occurred for an order judicially establishing the fact of birth. This is an expensive procedure and involves loss of time and effort. Furthermore, the average expense for establishing fact of birth including court and attorney fees is about \$100.

American Board of Obstetrics and Gynecology.—The annual written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 4, 1941, at 2 p. m. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

The following action regarding case records to be submitted by candidates taking the Group B, Part I, examination after January 1, 1942, was passed by the Board at its annual meeting in Atlantic City, New Jersey, on June 6, 1940: "Case records submitted by candidates must be of patients treated within four years prior to the date of the candidate's application. The number of cases taken from one's residency service should not be more than half (25) of the total number of fifty (50) cases required."

Applications for admission to Group B, Part I, examinations must be on file in the secretary's office not later than October 5, 1940.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting at Cleveland, Ohio, immediately prior to the June, 1941, meeting of the American Medical Association.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I and Part II examinations.

For further information and application blanks, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Training Requirements.—In response to numerous inquiries regarding special training requirements, the Board desires again to announce that there are three methods of meeting these requirements for admission to the Board examinations. First, by the residency system; second, by the partial residency and partial assistantship method; and third, entirely by the assistantship or "preceptorship" method. Details of the residence requirements are given in the Board booklet, sent by request.

The Board will accept in lieu of the formal residency service the training acquired by a candidate serving on an assistant or dispensary staff of an obstetrical and gynecological division of a recognized hospital, under the direction of a recognized obstetrician-gynecologist (preferably a Diplomate). The time required for this type of training must be longer than with the formal, more intensive resi-

dency type of training, and the allowance of time depends upon the duties and responsibility given the candidate. Applicants lacking all formal special training should have a minimum of five years of hospital clinic, or assistant hospital staff appointments in the specialty, under approved direction. Teaching appointments without accompanying hospital staff or clinical appointments will not satisfy the Board requirements. A special form amplifying the original application must be filled out to cover the details of such assistantship, or preceptorship type, of training. The Board approves for special training, work done in institutions approved jointly by the Board and by the Council on Medical Education and Hospitals of the American Medical Association.

Mother and Infant Death Rate High in Low Income Group.—Although recent progress in the reduction of maternal and infant mortality in the United States has been most gratifying, there remain large areas and large groups of the population where the surface of the maternal and child health service problem has hardly been scratched, George St. J. Perrott, chief of the Division of Public Health Methods of the National Institute of Health in Washington, D. C., told delegates who assembled at a two-day institute on maternal and child health sponsored by the current Summer Session on the Los Angeles campus of the University of California.

"Maternal mortality in the United States reached the lowest figure on record in 1938 and provisional rates indicate a 9 per cent further decrease in 1939. Infant mortality has been cut nearly in half during the past twenty years. Maternal and child health services, services for crippled children, and general public health services have been greatly expanded. Public health may well point with pride to its accomplishments," Doctor Perrott told the Los Angeles institute.

A satisfactory prenatal, delivery, and postnatal care program for all expectant mothers in the United States would consume some 23,000,000 physician hours, or the full-time services of over 10,000 physicians; it would require 23,000,000 hospital days, or the continuous and complete occupation of 1,000 sixty-three-bed hospitals; it would necessitate the full-time services of nearly 10,000 nurses and, in addition, laboratory services for tests of various kinds.

Health Officers to Meet in San Diego.—The Department of Health Officers of the League of California Cities will hold its annual meeting in San Diego, September 16 to 19, 1940. Dr. George Parrish, city health officer of Los Angeles, and president of the department, has appointed a program committee that is working with the secretary of the League of California Cities in preparation of a program for the meeting. It is anticipated that there will be a large attendance.

Under a new section of the Health and Safety Code, which became effective September 19, 1939, "the actual and necessary expenses of the county health officer incurred while traveling to and from, and while attending the annual convention of his association or of any other meeting designated by the board of supervisors, shall be a county charge. The expense of attending the annual convention of his association shall not exceed the sum of \$50." It is hoped that the governing bodies of all cities and counties in the State may make early provision for the traveling expenses of their health officers, in order that they may attend this meeting in San Diego on September 16 to 19.

The officers of the Department of Health Officers of the League of California Cities for 1940 are: President, George Parrish, M. D., City Health Officer, Los Angeles; vice-president, John D. Fuller, M. D., County Health Officer, Santa Cruz; vice-president, R. L. Kaufman, M. D., City

and County Health Officer, Riverside; secretary-treasurer, Walter M. Dickie, M. D., Berkeley; representative of Department of Health Officers on the Executive Board, League of California Cities, Herbert F. True, M. D., City Health Officer, Sacramento.

Studies on Vitamin D Damage Discussed.—Damage caused by overconsumption of the sunshine vitamin D may be controlled, or at least cut down, by overdoses of harmless vitamin A, according to scientists of the University of California College of Agriculture writing in the *Journal of Biological Chemistry*.

Dr. Agnes Fay Morgan, N. Shimotori, and J. B. Hendricks reported in the *Journal* that experiments with dogs and rats have shown that presence in the animal body of excessive amounts of vitamin A seems to protect the animals from the toxic effect of overdoses of vitamin D.

This new evidence is believed important to questions of human nutrition since, when taken in excess, vitamin D is highly toxic to humans. The appearance on the market of many irradiated products containing this vitamin has caused concern in medical circles. Physicians have warned against consumption of overlarge quantities of these products by people unfamiliar with the effect of vitamin D and the amount which can be safely consumed.

In the experiments vitamin D produced artificially by subjecting sterols, alcoholic substances found in the skin of animals, to ultra-violet rays produced more severe symptoms, when consumed in excess, than did natural vitamin D contained in liver oils of fish, such as tuna and cod. These liver oils also contain the protective vitamin A. This fact, says the scientists, indicates the advisability of obtaining necessary vitamin D through natural products rather than irradiated ones.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Parran Allots Venereal Fund

Washington, Aug. 2 (UP).—Surgeon General Thomas Parran today allotted \$5,672,388 in Federal funds among the states and territories to combat venereal diseases. A special fund of \$458,600 was divided among states where large numbers of troops will be concentrated. Explaining venereal diseases "exact a very large toll of man-days and efficiency from the armed forces," he said "it is important to note that a large proportion of infections originate in the communities of the nation before enlistment."—*San Francisco News*, August 2.

* * *

San Francisco Physicians Ask City Rate Reforms

A new schedule of fees covering medical services under the Municipal Employees' Health Service System has been proposed by the County Medical Society, and forwarded to the city's Health Service Board for consideration, Dr. L. Henry Garland, secretary of the Society, said today.

Numerous changes are included in the fee schedule, with some charges being advanced and others being reduced.

During the first year of operation of the City Employees' Health System, the doctors declare, they contributed more than \$132,000 in free medical services.

The physicians' statement expressed the hope the new schedule will be adopted, "since it represents the wishes of the physicians actually providing professional care to the municipal employees."—*San Francisco Examiner*, July 25.

* * *

Migrants

Remedy Needed at the Source

The Board of Directors of the California State Chamber of Commerce has approved a series of recommendations for treatment of the migrant problem, which is a matter of continuing and growing concern to this State.

The recommendations are both broad and reasonable.

They naturally deal with the vital California interest in the situation—an interest which has not always been ade-

quately considered, and has sometimes been maliciously misrepresented.

But they also deal in a thoroughly humanitarian manner with the interests and welfare of the migrants themselves, approving without restraint most of the measures for alleviation and assistance undertaken by local communities, State and Federal Government.

However, the recommendation properly put first is that which deals with the causes of the problem and thus its cure.

This is the recommendation "that Federal programs of relief and rehabilitation in the principal states of out-migration be maintained and further increased, so far as possible, by the greater concentration of available funds in such areas."

While it perhaps could not be said with entire accuracy that the migrant problem begins and ends with alleviatory measures in the states from which the migrants come, that is the obvious point at which the situation can be successfully attacked.

The overwhelming migration in recent years of indigents into California has not been a normal movement, comparable with any historical precedents.

The migrants were originally a fixed people, with their family roots deep in their homeland.

They became unable to subsist in that homeland, due to drought, dust storms, mechanization of agriculture and perhaps other abnormal conditions which were no fault of the people—and were certainly no fault or responsibility of California.

Those conditions can and should be corrected—first, to create and restore livable standards for the people remaining in the affected areas; and second, to make it possible for those who have migrated to return if they desire to do so—as many of them do.

California claims a clean record and a clear conscience on how it has treated the migrants, as its mounting tax and relief rolls attest.

But California rightfully protests being made the scapegoat for conditions of deterioration and neglect in other sections of the country.

The place to cleanse a poisoned stream is at the source of the poison, and not at the fountains where the people refresh and sustain themselves.

It is perhaps not generally understood, even in California, what staggering proportions the migrant problem has attained.

In ten years, the net migration into the State has been more than 1,200,000 persons.

At least 850,000 of that number have arrived in the last five years.

Half of these, or most of the breadwinners, are potential additions to the employable labor force of the State which already had distressing unemployment among its own people.

This is most certainly a national problem.

Let it be solved where responsibility for it in all truth and reality begins and ends—Editorial, *San Francisco Examiner*, July 24.

* * *

Social Security Receipts Shown

Five-Year Collections in California Amount to \$418,949,867

San Francisco, Aug. 5 (AP).—In the past five years Federal and State tax collections in California for Social Security have amounted to \$418,949,867, a State Chamber of Commerce announcement said.

Of the total, employers in California paid \$274,697,711, the announcement stated. Employers and workers contributed equally to the \$119,159,801 collected for Federal old-age insurance.

Collections for unemployment insurance amounted to \$277,897,084, of which the major portion, \$261,704,574, went to the State unemployment insurance program.—*Los Angeles Times*, August 6.

* * *

California Gains 1,196,560 In Census

Claim State Certain to Get Three More Congressmen

California gained 1,196,560, or 21.08 per cent, in population during the last ten years, preliminary census figures for all of the fifty-eight counties showed today.

The 1940 figure is 6,873,811, compared to 5,677,251 in 1930.

As a result California is virtually certain to gain three members in Congress, giving the State twenty-three national representatives in the lower house instead of twenty.

The largest numerical increase was in Los Angeles County, which went up 568,719, or 25.7 per cent, to 2,777,211. Shasta County had the largest percentage increase, 106.5, rising to 28,754.

Other large percentage gains included:

Nevada, 81; Mariposa, 69; Mono, 68; Kern, 61; El Dorado, 58; Yuba, 50; Madera, 47; Plumas, 47; San Mateo, 41; San Diego, 38, and Tulare, 36.

San Diego made the second largest numerical increase, 68,814, advancing to 289,473.

Among the cities, Los Angeles went up 258,954 to 1,496,792, and San Diego, 54,043 to 202,038.—*Los Angeles Herald and Express*, July 27.

* * *

Board of Health Offices Unchanged

State Officials Drop Plan for Removal Here

Headquarters of the State Board of Health will remain in Sacramento instead of being transferred to Los Angeles, as previously announced, it was reported yesterday by department officials.

Under the present system, branch offices will be maintained both in this city and San Francisco.

Coördination of public health programs with national defense plans was pledged by Dr. Elmer Belt, board president, at conclusion of a local department session.

At the request of military authorities the Bureau of Sanitary Engineering has reviewed projects for sewage disposal in army and navy posts.—*Los Angeles Times*, August 5.

* * *

Population of California Listed by Counties

The table of California's population by counties follows:

County	1940	1930
Alameda	506,190	474,883
Alpine	319	241
Amador	8,959	8,494
Butte	42,851	34,093
Calaveras	8,214	6,008
Colusa	9,772	10,258
Contra Costa	97,805	78,608
Del Norte	4,772	4,739
El Dorado	13,172	8,325
Fresno	178,574	144,379
Glenn	12,207	10,935
Humboldt	45,538	43,233
Imperial	59,651	60,903
Inyo	7,576	6,556
Kern	133,531	82,570
Kings	35,012	25,385
Lake	8,045	7,166
Lassen	14,463	12,589
Los Angeles	2,777,211	2,208,492
Madera	25,327	17,164
Marin	52,520	41,684
Mariposa	5,458	3,233
Mendocino	27,775	23,505
Merced	46,845	36,748
Modoc	8,775	8,038
Mono	2,283	1,360
Monterey	72,860	53,705
Napa	28,414	22,897
Nevada	19,224	10,596
Orange	130,803	118,674
Placer	27,917	24,468
Plumas	11,557	7,913
Riverside	105,448	81,024
Sacramento	169,375	141,999
San Benito	11,592	11,311
San Bernardino	161,769	133,900
San Diego	289,474	209,659
San Francisco	629,553	634,394
San Joaquin	134,088	102,940
San Luis Obispo	33,145	29,613
San Mateo	109,298	77,405
Santa Barbara	68,207	65,167
Santa Clara	174,367	145,118
Santa Cruz	44,806	37,433
Shasta	28,754	13,927
Sierra	3,033	2,422
Siskiyou	28,531	25,480
Solano	48,779	40,834
Sonoma	67,573	62,222
Stanislaus	74,854	56,641
Sutter	18,702	14,618
Tehama	14,347	13,866
Trinity	3,969	2,809
Tulare	106,285	77,442
Tuolumne	10,871	9,271
Ventura	68,883	54,976
Yolo	27,498	23,644
Yuba	16,992	11,331
Totals	6,873,811	5,677,251

—*Los Angeles Times*, July 28.

Twenty-Five Largest Cities in the United States

Washington, July 31 (AP).—Census counters scrambled population standings of America's big cities today to create a "25-biggest" list for 1940.

The list generally includes the same cities as in 1930, but thirteen of the twenty-five have different ranks than ten years ago.

Houston, Tex., and Denver, Colo., made the grade for the first time, crowding out Jersey City, N. J., and Portland, Ore. Houston claimed the biggest jump, from twenty-sixth to twenty-first. Jersey City had the worst fall of the big cities, from twenty-third to thirtieth.

In line with forecasts that rural territories, especially suburban areas, were gaining at the expense of big cities, eight of the first twenty-five showed losses—Philadelphia, Cleveland, St. Louis, Boston, Pittsburgh, San Francisco, Newark and Rochester, N. Y.

Washington won first honors among major cities for population gain, going from 486,869 to 663,153 in the decade. Census officials attributed this jump almost exclusively to the doubling of Federal pay rolls in the District of Columbia.

Preliminary figures—complete except for transients and other minor factors not likely to change standings—give the top twenty-five places to these cities:

1940 Rank	City	1930 Rank	1940 pop.	1930 pop.
1	New York	1	7,380,259	6,930,446
2	Chicago	2	3,384,556	3,376,438
3	Philadelphia	3	1,935,086	1,950,961
4	Detroit	4	1,618,549	1,568,662
5	Los Angeles	5	1,496,792	1,238,048
6	Cleveland	6	878,385	900,429
7	Baltimore	8	854,144	804,874
8	St. Louis	7	813,748	821,960
9	Boston	9	769,520	781,188
10	Pittsburgh	10	665,384	669,817
11	Washington	14	663,153	486,869
12	San Francisco	11	629,553	634,394
13	Milwaukee	12	589,558	578,249
14	Buffalo	13	575,150	573,076
15	New Orleans	16	492,282	458,762
16	Minneapolis	15	489,976	464,351
17	Cincinnati	17	452,852	451,160
18	Newark	18	428,236	442,337
19	Kansas City	19	400,175	399,746
20	Indianapolis	21	386,170	364,161
21	Houston	26	386,150	292,352
22	Seattle	20	366,847	365,583
23	Rochester	22	324,694	328,132
24	Louisville	24	318,713	307,745
25	Denver	29	318,415	287,861

—*Los Angeles Times*, August 1, 1940.

* * *

San Francisco Health Service

\$23,666.24 Paid Doctors for June

After a special board of directors meeting last night, the Municipal Employees Health Service System announced the payment of \$23,666.24 in doctor bills for the month of June.

The rate of payment was equal to 87 cents on the dollar of total bills rendered for service to members during the month and was 9 cents greater than the payment in May and 30 cents greater than in the same month of 1939.

A plan for osteopathic services to members was also approved by the directors and sent to the city retirement board for final approval.—*San Francisco Examiner*, August 20.

* * *

Insurance Battle

Firms Oppose State Suits

State Insurance Commissioner Anthony Caminetti's suits to take control of the Mount Moriah and Physician's Life Insurance firms had new repercussions yesterday.

On the applications of attorneys for the companies, Presiding Judge T. I. Fitzpatrick ordered the insurance commissioner to show cause August 28 before Superior Judge Frank T. Deasy why he should not be restrained from seeking proxies from policyholders.

The seeking of proxies from the policyholders, the attorneys contended, would ultimately deprive the policyholders of their rights to oppose Caminetti's suits, and would likewise destroy good will in the companies, one of their major assets.

Further, the petitions also alleged that the insurance commissioner lacked sufficient cause for his suits to take control of the companies, and that there was no basis for the allegations of danger to policyholders contained therein.—*San Francisco Examiner*, August 20.

143,459 Given Old-Age Aid in California

Sacramento, August 23 (INS).—A total of 143,459 persons in California received \$5,445,638 in old-age assistance during July, it was announced today by Martha Chickering, director of the State Department of Social Welfare.

This was an average of \$37.96 per person for the month as compared with an average of \$37.99 for the preceding month.

Largest amount doled out in a single county went to Los Angeles where 53,523 persons were given \$2,210,487.

In San Francisco County, 10,895 persons received \$416,840, and in Alameda County 8,399 old persons were given \$311,698.

Other large payments were:

San Bernardino, \$186,954 to 4,881 persons; San Diego County, \$282,385 to 7,278 persons; Santa Clara County, \$138,319 to 3,665 persons, and Fresno County, \$126,213 to 3,307 persons.—San Francisco *Call-Bulletin*, August 23.

LETTERS

Concerning Pacific States Medical Executives' Conference.

(COPY)

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE
OFFICE OF THE SECRETARY-TREASURER
PORTLAND, OREGON

Dr. George H. Kress, Secretary,
California Medical Association,
450 Sutter Street,
San Francisco, California.

Dear Doctor Kress:

Tentative plans provide for holding the Fourth Annual Session of the Pacific States Medical Executives' Conference at Portland on Sunday, December 8.

Since the 1939 Session in Seattle, the Nevada State Medical Association has affiliated with the Conference. Six Pacific States organizations are now members, including the California, Oregon, Washington, Idaho, Montana, and Nevada state associations.

The officers of the Conference are hopeful that each participating association will send one or more delegates to this year's meeting. As amended at the 1939 Session, the by-laws of the Conference provide as follows:

"Each constituent state medical association shall have three official or voting delegates to serve for three years or until their successors are selected and qualified; provided, that, beginning in 1940, one delegate shall be selected to serve for one year, one to serve two years, and one to serve three years.

"(It is suggested that the following officers and committeemen of the respective constituent state associations be considered for delegates; the President, the President-Elect, the Secretary, the Chairman of the Committee on Public Relations, Delegates to the American Medical Association, members of the Council, or other governing body, or other members.)"

You will observe that this provision appropriately leaves each affiliated association free to determine who its delegates shall be, as well as the manner of their selection.

We shall greatly appreciate it if you will arrange at an early date to have your association select its delegates. Please also obtain the authorization of your Council, Board of Trustees, or other governing body, for the attendance of at least one and, if possible, all three of your delegates at the coming meeting in Portland.

President H. E. Rhodehamel of Spokane has already written you soliciting the suggestions of your association as to subjects for discussion at the coming meeting. If you have not already done so, he will appreciate it if you will submit a list of suggested topics of common interest as soon as possible.

The annual dues of the Conference are \$10 for each affiliated association. A statement for 1940 dues is enclosed.

We shall greatly appreciate your coöperation in giving prompt attention to the subjects of this letter.

In pleasurable anticipation of your attendance at the coming meeting, we are

Medico-Dental Building.

Very sincerely yours,

PACIFIC STATES MEDICAL EXECUTIVES' CONFERENCE.
By CLYDE C. FOLEY, *Secretary-Treasurer*.

Concerning Sales Tax on Drugs Dispensed to Patients.

July 31, 1940.

Dear Doctor Babington:

Doctor Kress, secretary of the California Medical Association, forwarded to me a copy of your letter of July 16, 1940, in which you asked for information concerning the applicability of the sales tax to drugs furnished to patients as a part of treatment.

It is my opinion that there is little doubt that the physician is the consumer of the drugs and not a seller. The sales tax is collected from the person making the last sale of the property to the person who will consume the same. Therefore, it is up to the druggist who sells the drugs to the physician to collect and report the tax.

The Sales Tax Act makes no express statement in this regard nor has the question ever been submitted to a court. However, two rulings of the Board of Equalization are sufficiently analogous to merit the conclusion stated above.

Rule 16 of July 1, 1935, provides that dentists are to be considered as consumers and not sellers of the materials which they place in the patient's mouth. This would include gold inlays, etc., which are of greater value in proportion to the service rendered than are most of the drugs which a physician furnishes to patients.

Rule 25 of July 1, 1935, provides that drugs and materials furnished to patients by a hospital while the patient is confined in the hospital are not considered as being sold to the patient. However, the rule provides that where the hospital does make an outright sale of medicines, etc., to the patient and makes a separate charge therefor, the hospital must report the transaction as a sale.

Under the holding that a hospital is liable for a tax where it sells medicines and drugs directly to the patient at a specified price, it would be well for physicians to avoid specifying any charge to their patients for drugs given them and merely include the same as part of the general treatment fee.

There is a limit within which the transfer of property may be included as a part of a service, an example of which can be seen in the rule relating to optometrists.

Where an optometrist examines the eyes and then furnishes glasses, he is allowed to deduct from the total amount charged a reasonable amount for the examination services but must pay a tax on the balance. However, that situation is clearly distinguishable from your own.

I hope that this will be sufficient for your needs.

Very truly yours,

HARTLEY F. PEART.

Concerning Public Health Supervision of Passenger Boats.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

August 2, 1940.

To the Editor:—No other ships in the world have the safety afforded travelers by American shipping firms. Aside from the established high degree of the navigating

and engineering personnel, there is the guaranty of public health supervision which provides utmost protection during a voyage. The latter is well exemplified in the practices of the two largest passenger-carrying lines in San Francisco. Several years ago these firms solicited and obtained the inspection service of the San Francisco Health Department as a special inspectional supervision over each ship leaving San Francisco. Bacteriological analysis of drinking water and milk, and strict inspection of other food products by well-trained inspectors are part of the routine. Careful investigation is made of the general sanitation of all ship's quarters, and each boat is thoroughly examined to determine the extent of rodent or pest infestation. Rigid methods are constantly employed to keep the latter at an irreducible minimum.

In addition to this, all American passenger-carrying vessels maintain hospitals, treatment rooms and dispensaries that are operated by exceptionally well trained and qualified physicians and nurses. The American ship surgeon of today is not only well trained in medicine and surgery, but also in public health. He acts in the capacity of family physician, emergency surgeon and health officer to all passengers and crew members. All of which is indicative of the efforts being made by the American shipping industry to offer the highest degree of service and safety to the traveling public. This particular feature of shipping, however, is accepted by the public as a matter of course in the same manner as these services are received by the average citizen in normal habitat. They seem to know that such services protect every member of their family each day, but never think of the time, money and energy necessary to maintain such protection.

Very truly yours,

J. C. GEIGER, M. D.,
Director of Public Health.

Concerning Proposed License Tax on Businesses and Professions.

(COPY)

SAN FRANCISCO CHAMBER OF COMMERCE
333 PINE STREET

August 1, 1940.

To the Editor:—Opposition to the proposed License Tax Ordinance is expressed in a resolution, copy of which is attached, unanimously passed at a meeting of representatives of property owners and taxpayers, retailers, industrialists, organized labor affected by such taxation, and large and small businesses. At the meeting it was revealed that many of the individual property owners' organizations represented had already passed similar resolutions.

We are hopeful that you will agree with this resolution and will desire to have each organization of which you are a member pass a similar one. A suggested form for such purpose is also enclosed. It is recommended that when such a resolution is passed that the original be addressed to the Honorable Board of Supervisors, City Hall, San Francisco, but that it be sent to Will L. Merryman, San Francisco Chamber of Commerce, 333 Pine Street, so that he may present all such resolutions to the Board at one time. Individual copies of such resolutions should be sent to each member of the Board of Supervisors and to the Mayor.

It is important that you or a representative attend all meetings of the Finance Committee, and, most particularly, meetings of the Board of Supervisors from now on until this License Tax matter is disposed of. (For announcements of meetings of Finance Committee, watch the newspapers. The next meeting of the Board of Supervisors will be Monday, August 5, at 2 p. m.)

Sincerely yours,

WALTER A. HAAS, *President.*

WHEREAS, The proposed Occupational License Tax Ordinance before the Board of Supervisors will so increase the present heavy burden of taxation upon business, industry, and occupations as to discourage the continuance of industries now located here, as well as the establishment of new enterprises and plants in San Francisco; and

WHEREAS, Experience has shown that imposition of new forms of taxation does not ultimately reduce the tax rate on real property, but merely increases the total municipal budget expenditures without benefit to the taxpayers generally; now, therefore, be it

Resolved, That..... hereby goes on record unanimously as most vigorously opposed to the enactment of the proposed license tax ordinance both as to new occupations and businesses proposed to be taxed and as to the old classifications formerly so taxed under ordinances recently repealed; and be it further

Resolved, That this group call for immediate study and investigation by representatives of real estate owners and taxpayers, business, labor and industry, in cooperation with the Board of Supervisors and municipal officials, to analyze municipal expenditures and appropriations to the end that definite recommendations be made for reduction of costs of municipal government and a consequent reduction of tax rate without the imposition of new forms of taxation; and be it further

Resolved, That copies of this resolution be sent to each member of the Board of Supervisors and to the Mayor.

Concerning Serologic Tests for Syphilis.

(COPY)

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON

June 27, 1940.

To the Editor:—Consideration is now being given by the U. S. Public Health Service to the organization of an evaluation study of the performance of original serologic tests for syphilis by the authors of these techniques. This study will be directed by the Committee on Evaluation of Serodiagnostic Tests for Syphilis.

It is desired to bring this proposed investigation to the attention of every interested serologist. Your cooperation by publishing the attached announcement in an early issue of your medical journal will be greatly appreciated.

Sincerely yours,

THOMAS PARRAN,
Surgeon-General.

1 1 1

(COPY)

Announcement of a Study to Evaluate Original Serologic Tests for Syphilis

More than five years ago the Committee on Evaluation of Serodiagnostic Tests for Syphilis, in cooperation with the United States Public Health Service, conducted a study to evaluate original serologic tests for syphilis or modifications thereof in the United States. The results of this study were published shortly after the investigation was completed.¹

Consideration is now being given by the Committee to the organization of a second evaluation study of original serologic tests for syphilis or modifications thereof within the next year. If the need for an investigation of this kind seems to justify the cost, invitations will be extended to the authors of such serologic tests who reside in the United States, or who may be able to participate by the designation of a serologist who will represent them in this country. The second evaluation study will be conducted utilizing methods comparable to those employed in the first study.²

Serologists who have an original serologic test for syphilis or an original modification thereof and who desire to

1 Ven. Dis. Inform., 16:189. Washington, June, 1935.

J. A. M. A., 104:2083. Chicago, June 8, 1935.

2 J. A. M. A., 103:1705. Chicago, December 1, 1934.

participate in the second evaluation study should submit their applications not later than October 1, 1940. The applications must be accompanied by a complete description of the technique of the author's serologic test or modification. All correspondence should be directed to the Surgeon-General, United States Public Health Service, Washington, D. C.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Legal Responsibility for Improper Diagnosis

Naturally every physician or surgeon is interested to know just what his course of conduct must be to keep himself immune from liability under a malpractice action. However, it is even more important for him to be aware of a few principles which will assist him in avoiding even the filing of a lawsuit, since the mere filing may not only be costly but professionally embarrassing even though the physician eventually wins the suit.

It is true that a physician or surgeon may go through a life of practice and never become involved in litigation, even though he makes no real attempt to avoid the same. The same can be said, however, of the driver of an automobile; some drivers seem to disobey all rules of the road and yet never have a serious accident. However, there are few who will argue that because of those instances drivers generally may disregard the rules of careful driving.

Although a number of these articles have covered the standard of care required during treatment generally, one of the constant sources of trouble is the injury resulting from alleged erroneous diagnosis. A review of a few decisions wherein physicians have been held liable for improper diagnosis may be helpful in outlining the proper bounds of caution.

First of all, a physician must keep abreast of the times. He can not rely on a method of diagnosis which is considered by physicians generally as insufficient in this modern day, even though it is the physician's honest opinion that the particular method of diagnosis is satisfactory. Again it has been held that one physician is not entitled to rely on the diagnosis of another and give treatment accordingly. If a patient employs the services of a physician, the physician is expected to satisfy himself as to the nature of the ailment involved before proceeding with treatment.

In a midwestern case, a physician examined a patient's shoulder and saw that it was badly bruised, but did not take into account the possibility of dislocation. After ten weeks of treatment, the patient went to another physician who made a physical examination of the shoulder and discovered that the head of the humerus was below the glenoid cavity in which it should naturally be and raised against the lower edge of the scapula; in other words, a subglenoid dislocation. Expert witnesses at the trial testified that a subglenoid dislocation should be readily discovered, and it was held that the jury was warranted in finding negligence on the part of the first physician.

Another physician was sued by a patient who had been injured by the overturning of his wagon, the team becoming frightened, running away with the wagon, and dragging the patient over rough ground for some distance. The physician, who was called within an hour, failed to discover a fracture in the arm between the elbow and shoulder and a dislocation in the arm at the shoulder joint, and, as a

consequence, failed to treat the injuries. The muscles of the arm atrophied, the shoulder joint stiffened, and the arm became practically useless. The physician was held liable on the ground that the injury could have been discovered by ordinary examination. The physician was not allowed to defend upon the ground that the community was a rural one and that none of the other physicians in the district would have been sufficiently competent to have discovered the injury.

An osteopathic physician was held liable for injuries resulting from the violent manipulation of a child's hip where his diagnosis was dislocation of the hip. He had been advised that the child's family physician had diagnosed the trouble as disease of the hip. It was later discovered that the hip had been diseased and the osteopathic physician was held to the same degree of skill in diagnosis as would be applied by physicians generally.

Again, a surgeon has been held guilty of malpractice in treating as a mere bruise a fracture of the neck of the femur where, when the patient is placed on his back, his foot lies over on one side without power on his part to control it.

There are numerous cases in which the physician has been unable to determine whether a woman's condition is that of pregnancy or ovarian cyst. Some cases have held that a mistake on the part of the physician under some circumstances is not negligence, where others have held to the contrary. The issue of liability would thus be up to the jury, which would have the right to determine the existence of negligence under the circumstances present.

There are many instances in which the physician is blamed for not having resorted to the use of x-ray in making his diagnosis. Again the question of liability is one for the jury, to be determined from all of the circumstances. Thus, verdicts for the plaintiff have been rendered where a dentist injected an anesthetic into the gum and extracted a tooth without first taking an x-ray to determine the cause of the inflamed and swollen condition of the gums or without first taking some preliminary measures to reduce the infection; and where a surgeon, instead of using x-ray after the reduction of a fracture, used steel tape in making measurements of the limb, which measurement proved to be unsatisfactory.

There are certain instances in which although x-ray has been used, the physician has been held liable for mistake in analyzing the same. Thus, it has been held that a physician did not use ordinary skill or apply the knowledge expected of practitioners in his community where there was evidence that there was sufficient clearness and detail in an x-ray picture of a limb to disclose the presence of a fracture, but the physician did not analyze it with sufficient care to become aware of the fracture.

It is interesting to note that practitioners have been held to a reasonable degree of care and diagnosis regardless of the school of treatment professed to be applied by them. Thus, a chiropractor has been held liable for treating as a general nervous condition due to some derangement of the stomach, a condition which, in fact, was due to intracranial pressure resulting from the growth of a tumor.

In deference to the medical profession, it should be pointed out that the above examples are very much the exception rather than the rule in relation to suits for erroneous diagnosis. The courts will normally favor the physician wherever reasonable minds might have disagreed on the analysis of the symptoms. However, since there are decisions such as the above, it has been felt advisable to remind the profession that there is a constant danger that some patient may cause trouble where there has been an error in diagnosis and that, accordingly, physicians must be on their toes to protect themselves.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 9, September, 1915

From Some Editorial Notes:

The State Medical Society and Plague.—All the various jubilations over the eradication of plague in San Francisco and the development of the idea of a plague-free city by properly constructing all buildings so that they are rat-proof, have left out of the record of events the most essential part in the work which was played by the Medical Society of the State of California. At this particular time, when so much reference is being made to the plague fight and the bearing of the successful result upon the possibility of having an Exposition in San Francisco, it seems not unfitting to go back a bit, think of the facts as they were, and place a few words upon the record. To that end and for that purpose we have asked a gentleman who was very active in his interest in the plague situation from the very beginning, to set forth the facts in relation thereto which came within his personal knowledge. The "Williamson Board of Health," to which he refers, was the board thrown out—but refusing to go out—by the then Mayor of San Francisco. Dr. John Williamson was president of the board. The President of the State Society, at the time the mass meeting was called in 1908, was Dr. George H. Evans of San Francisco. Mr. King and Mr. Friedlander, of the Merchants' Exchange, were about the only members of commercial bodies who took the trouble to come to the meeting. The law passed making it a felony to say that plague existed in the State of California; his representative, Doctor Anderson, did what he could to help him along. A more unwholesome condition of things than existed at that time can hardly be imagined.

In 1900, plague was epidemic in Chinatown. I have forgotten the total number of verified cases (121, I think), but the writer personally attended a great many autopsies, reports of which were wired to the *Journal* of the American Medical Association and published. Notwithstanding the efforts of the Williamson Board of Health at that time, and the Public Health Service under Doctor Kinyoun, to make public the facts, a crusade of vilification and denial was carried on by the business interests and the press which was shameful in the extreme. While business men and press representatives personally and privately expressed their conviction that plague existed, the policy of the press was one of suppression of the facts.

About this time a Federal Commission, composed of Professors Barker, Novy and Flexner, was appointed by the President to investigate plague in San Francisco. The report of this commission established beyond doubt the existence of this disease and its report became a public record. In spite of such undisputed proof, the policy of denial was persisted in by the press and business interests, aided by Dr. Winslow Anderson and his paid "bacteriologist."

Early in 1908, officers of the State Medical Society, who had been watching with alarm the constantly increasing incidence of plague among the rats captured, concluded that the influence of the organized profession of the State must be exerted in order to obtain the publicity necessary, so that measures for eradication could be undertaken. The influence of the Public Health Service under Doctor Blue, the City Board of Health, and a committee of the County Medical Society had been unsuccessful in forcing publicity.

(Continued in Front Advertising Section, Page 7)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

The results of the written examination, held in San Francisco June 25 to 27, show that 155 graduates of medical schools, including several from foreign countries, passed the physician and surgeon's examination, and nine failed.

The highest mark (92½ per cent) was made by Otto Allen Will, Jr., M. D., a graduate of Stanford University School of Medicine, June 16, 1940.

Twenty-one chiropodists passed, with no failures.

Two drugless practitioners passed and four failed.

News

"Dr. A. Elmer Belt of Los Angeles has been chosen as new president of the California State Board of Health, it was announced yesterday. A graduate of the University of California Medical School in 1920, Doctor Belt has been an instructor there, and at present is an associate professor in the College of Medical Evangelists and the California Institute of Technology at Pasadena." (*Los Angeles Examiner*, July 10, 1940.)

"... Dr. Vincent Carroll, Laguna Beach, was appointed by Governor Olson to a four-year term and Dr. J. M. Pendergast to a two-year term as members of the Board of Osteopathic Examiners. . . ." (*Los Angeles Examiner*, July 9, 1940.)

"'Dr.' Nettie Vollmer, 65, 335 Market Street, Oakland, a self-styled magnetic healer, who can work by 'remote control' if she has a patient's photograph, gave herself up yesterday. The nice man with stomach trouble turned out to be a detective, but Nettie failed to 'foresee' this. The 'patient' was T. P. Hunter, operative for the State Board of Medical Examiners, who obtained one of Nettie's circulars and dropped in to see her. Nettie got out a magnifying glass, looked at his tongue, and told him he was being 'doped by short wave' by someone who wanted to marry him. Hunter asked Nettie to help him. Nettie is alleged to have said that, for \$100, she could 'put the hex' on Hunter's persecutor and relieve his pains. Hunter had a better idea, told Nettie to be in police court at 10 o'clock. She was. She pleaded 'not guilty' to violation of the State Business and Professions Code and her trial date was set for July 24." (*San Francisco Chronicle*, July 19, 1940.)

"The Municipal Employees Health Service Board last night voted approval of payment of \$22,873.57 to the system's doctors, 78 cents on the dollar for their service. The payment is 8 cents more than the April amount, but 4 cents under February's. . . ." (*San Francisco News*, July 18, 1940.)

"... The City Retirement Board has rejected Plan 2, which would have provided services of osteopaths and chiropractors to city employees who are members of the Health Service Board. Plan No. 1 provides service only by doctors of medicine." (*San Francisco Chronicle*, July 25, 1940.)

(Continued in Back Advertising Section, Page 37)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.



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TWENTY-FIVE YEARS AGO

(Continued from Front Advertising Section, Page 30)

liomyelitis. Today, the subject of "carriers" commands our attention, and the laboratory must be prepared to examine excreta for the presence of typhoid bacilli and nasal and throat secretions for meningococci and diphtheria bacilli. . .

From an Original Article on "Shall the Medical Society of the State of California Have an Examining Board?" by William Taylor Barry, M. D., Santa Barbara.—Twenty years ago the examining board for the State was the Medical Board of the State Medical Society—the recognized legal (per act of Legislature) certificate-granting body for California. The methods of this board were extremely simple. Upon the presentation of a diploma from a recognized chartered medical college, and the payment of a fee of \$5.00 for registration, license to practice medicine in the State of California was issued. Since that time numerous changes in the medical law have been arrived at, down to the present year with its composite Board of Medical Examiners, together with reciprocity with certain states. Now the question is: "Shall the Medical Society of the State of California return to first principles—with this difference?"

From an Original Article on "Banti's Disease," by Henry H. Lissner, M. D., Los Angeles.— . . . According to Banti the condition begins with enlargement of the spleen, which is followed by anemia, and lastly terminates in liver cirrhosis. It is therefore not possible definitely to make a diagnosis of Banti's disease in those forms of liver cirrhosis in which there is an enlarged spleen. The attempt to differentiate certain forms of splenomegaly from splenic anemia

is also difficult to carry out, since an enlarged spleen occurring with anemia may be caused by other conditions, i. e., malaria, leukemia, pseudo-leukemia, tuberculosis, and hereditary syphilis. However, it may be seriously considered that, in those cases where the Banti symptom complex is present splenectomy is a curative measure, in that anemia, liver swelling an icterus disappear.

Banti's exhaustive reports showed a primary change in the spleen first, an enemic stage lasting from three to five years, but which may also last ten years. The large, smooth splenic tumor is generally discovered accidentally. Not infrequently there are fever periods which last for irregular intervals. The leukocyte and detailed blood picture is unaltered. Then comes a transitional stage in which icterus and gastro-intestinal symptoms occur. The third, or ascitic stage with profound icterus, fever, lack of leukocytes and profound anemia, lasts from one-half to one year, and terminates with intestinal or gastric hemorrhage.

From "Society Reports":

California Pediatric Society, Northern Branch.—The fourth meeting of the California Pediatric Society, Northern Branch, will be held on Thursday evening, September 30, at 8:15, in the County Medical Library. The program will be as follows: I. Treatment of Paralysis Following Acute Anterior Poliomyelitis—Demonstration of Cases—Walter F. Schaller. II. Creolin in Scabies in the Infant—Douglass W. Montgomery. III. Study of the Problem of Dental Hygiene in Children—Guy S. Millberry.

It is hoped that anyone interested in child welfare problems will come to this meeting and join the Society. We will welcome all who are really interested in any phase of child welfare work. William Palmer Lucas, Secretary.

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Pediatric Society, Southern Branch.—On the evening of July 23, at a meeting held at the Barlow Medical Library, Los Angeles, the Pediatric Society of Southern California was organized. The officers elected were as follows: President, W. A. Edwards, M. D.; Vice-President, P. V. K. Johnson, M. D.; Secretary and Treasurer, Victor Stork, M. D.; Councilors, Henry Dietrich, M. D., and R. B. Mixsell, M. D.

The Society has for its object the advancement of the study of infancy and childhood, and to this end will include as associate members those interested in the various phases of child study.

It is planned to hold meetings from time to time, when papers will be read by men of authority in the field of Pediatrics.

An effort is being made to show the Government Child Welfare Exhibit in Los Angeles under the auspices of the Society.

♦ ♦ ♦

Southern California Medical Society, Fifty-Second Regular Semi-Annual Meeting.—Officers: F. W. Thomas, M. D., Claremont, President; W. T. McArthur, M. D., Los Angeles, First Vice-President; J. K. Swindt, M. D., Pomona, Second Vice-President; Walter Brem, M. D., Los Angeles, Secretary and Treasurer. Committee on Arrangements: R. E. Austin, San Diego, Chairman. . . .

From "San Francisco Session."—The reports of the proceedings of the Annual Session of the American Medical Association, held at San Francisco, which appeared in the JOURNAL last week, are gratifying evidence of the work being done by the organization. The attendance was fully

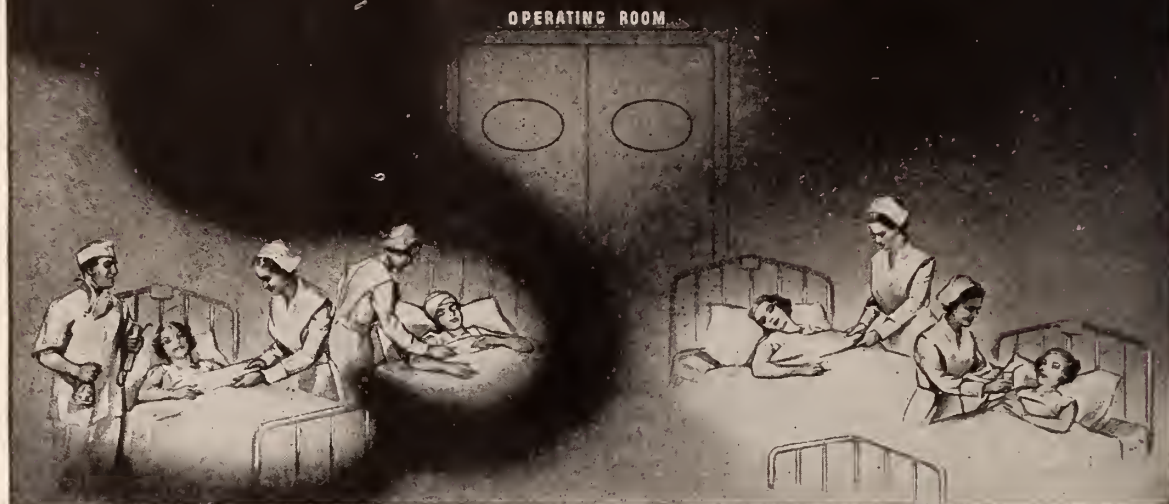
as large as the most optimistic expected. The number who registered from the Pacific Coast States proved the interest of the profession in that territory. The minutes of the House of Delegates show the efforts of the Association in advancing the usefulness of the profession in serving the public. The exhaustive study of the relations which physicians must meet in the sociologic conditions which prevail, especially in the development of workmen's compensation legislation, as they are presented in that portion of the report of the Judicial Council devoted to this subject, merits special attention. . . .

From "Report of the Tuberculosis Situation in San Francisco."—"The public measure most necessary for the control of tuberculosis in San Francisco at the present time is a special Tuberculosis Bureau of the Department of Public Health. This Bureau should be created with an annual appropriation of at least \$40,000 for the single purpose of fighting the 'White Plague' in San Francisco."

This is one of the chief recommendations included in a special report on tuberculosis conditions in the city, made by the San Francisco Association for the Study and Prevention of Tuberculosis to the Department of Public Health at the request of the latter.

The special Bureau would, according to the report, establish clinics in different sections of the city for free examination of patients; employ visiting nurses to coöperate with physicians in the care of patients and their families in the home; wage a campaign of education; supervise the disinfection of premises after death or removal of a patient; promote good housing, working and living conditions, and further investigate conditions in the city and make recommendations for bettering them. . . .

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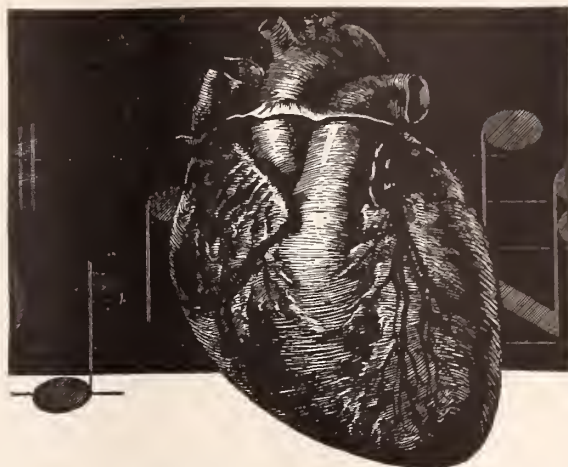
BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 152)

"The charges of practicing medicine without a license against St. Louis Estes, food lecturer, recently set for hearing on July 30 by Presiding Judge J. E. White, may not be heard until determination of the former complaint in which the court set aside his conviction by a jury on similar charges, it was learned Saturday. The retrial has been set for August 15. In the former trial the lecturer was convicted on ten counts of practicing medicine without a license, in which he faced a \$1,500 fine and 150 days in jail. Judge White granted a new trial when it was shown that a woman juror had served on a panel hearing charges against Estes two years ago. Ben K. Lerer represented the district attorney's office in the former trial. . . ." (San Francisco Recorder, July 15, 1940.) (Previous entries May, 1930; November, 1935; March, 1936; December, 1938; February and November, 1939; May and August, 1940.)

"What police characters inelegantly describe as a 'floater'—a judicial order to get out of town and stay out—was firmly applied yesterday to 'Dr.' Robert Faudree, 23-year-old 'graduate of the University of Calcutta Medical School,' authority and lecturer on rare tropical diseases, laboratory technician and very, very persuasive talker. 'Doctor' Faudree, who, it developed, isn't a doctor, and never saw Calcutta or its university, and doesn't know much more about tropical diseases than an Eskimo, received the 'floater' from Municipal Judge Frank W. Dunn after being found guilty of petty theft. Judge Dunn pronounced sentence after hearing Thomas P. Hunter, special agent for the State Medical Board, sketch the amazing medical career

(Continued on Next Page)



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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

of the young man in white. Faudree, testified Hunter, appeared on the local scene in March, went out to a reputable medical school, introduced himself as an old Calcutta 'grad,' and, before long, was lecturing to nurses on the topic of tropical diseases. Then Dr. Walter Rapaport, superintendent of Mendocino State Hospital, encountered young Faudree and was so impressed that he gave him a job as laboratory technician at \$176 a month. Faudree was in his laboratory, 'technicking,' when Hunter arrived to make inquiries. First, Hunter insisted upon seeing Faudree's credentials. Second, Hunter demanded return of valuable medical books which Faudree had drawn from the medical school library, and had neglected to return, despite repeated requests. Hunter became so insistent that Faudree finally broke down and admitted he was no doctor, no medical school graduate, no authority on tropical or other diseases, no laboratory technician." (San Francisco *Examiner*, July 26, 1940.)

"Dill Riddle Senne, 53, residing at Roseberg Avenue and Coffee Road, pleaded guilty in the justice court this morning to practicing medicine without a valid certificate required by the State, and was fined \$150 by Judge Stanton K. Helsley. Judge Helsley, who presides over the Ceres justice court but who is on duty here during Judge Leslie K. Floyd's vacation, ordered Mrs. Senne to pay \$50 of the fine, and then suspended the \$100 and placed her on probation for six months. Mrs. Senne, who described herself as a housewife, was arrested last night in her home by J. W. Williams, a special agent of the State Board of Medical Examiners, McKinley Thompson of the district attorney's office, and Deputy Sheriff F. E. Lockridge. Armed with a

search warrant, Williams went through the home and accumulated numerous bottles of pills and 'medicines,' examples of which were displayed in the courtroom today. . . . Mrs. Senne was accused of treating Mrs. Anna Denio of 812 Sixth Street, charging her \$3.00 a day over an extended period. She also was charged in the complaint with treating, on two occasions, Mrs. Luverne Swift, a resident of Modesto. After a treatment by Mrs. Senne, Mrs. Swift told investigating officers the woman said she 'can tell by the way parts of your body feel as to what is wrong. She claims most of the people who suffer from a so-called tumor or ulcer are really suffering from gas pockets.' Mrs. Swift said Mrs. Senne told her she had a 'gas pocket' in the chest, but by daily treatments might overcome it." (Modesto *Bee*, August 8, 1940.)

"Laura Miner, who gave her occupation as that of chiropractor and who is charged with practicing medicine without a license, today pleaded not guilty and demanded a jury trial when arraigned before Judge Dean Sherry. She is free on bail. . . . A few years ago Mrs. Miner was arrested here on charges of performing an alleged illegal operation." (San Diego *Tribune-Sun*, July 24, 1940.) (Previous entries July, September, October, and December, 1936; June, August and November, 1937.)

"Dope peddlers, like the erstwhile bootlegger, seldom are consumers of their own wares, Superior Judge Charles W. Fricke said today in discussing his subject, 'Control of Narcotic Addiction,' which he will present before the eighteenth annual chiropractic convention to be held in Los Angeles the week of July 29 to August 3. Judge Fricke,

(Continued on Page 40)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 38)

who studied medicine before he turned to the legal profession, has made an exhaustive study of the illicit narcotic business, and among other things says that the chief reason dope addiction breeds crime is the fact that habitual narcotic users must have approximately \$7 a day to satisfy their craving. Most of them do not have such a sum over and above their living expenses, so they turn to robbery or holdup to get money, he said." (Los Angeles Herald and Express, July 19, 1940.)

"Judge J. O. Moncur of Plumas County, in a decision placed on file in the superior court here, denied the request of Dr. N. T. Enloe of Chico for an injunction to prevent Dr. John Huffman White from practicing medicine in the Chico area. Doctor Enloe complained that when Doctor White was associated with him in the operation of the Chico Clinic, Doctor White signed a partnership agreement providing that after the dissolution of the partnership he would not practice in Chico for five years. Doctor White denied the agreement was a partnership, but merely a 'working agreement,' and that the provision therefore was in restraint of trade. Judge Moncur upheld this contention. . . ." (Sacramento Bee, July 20, 1940.)

"Accused of practicing medicine without a license, Mrs. Jean M. Campbell, 65, 804 Third Avenue, was arrested last night by Hal Randall, special agent for the State Medical Board. She later was freed on \$500 bail. Mrs. Campbell gave her occupation as a 'physical culture teacher.' The warrant for her arrest was issued by Municipal Judge Dean Sherry." (San Diego Union, July 25, 1940.)

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Vitamin B ₆	100 gamma
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"A slight matter of feminine forms that happen to be too slight brought Mrs. Myrtle E. Edwards, 40, into court yesterday on charges of practicing medicine without a license. Special Agent Joseph Williams of the State Board of Medical Examiners, who brought along some bottles of medicine and boxes of pills, appeared as complainant against Mrs. Edwards before Municipal Judge Theresa Meikle. After hemming and hawing some, he admitted the case had to do with the symmetry and prominence of certain details of the charmingness of women from an anthropometric viewpoint. 'Mrs. Edwards operates the Elga Laboratories,' he told the court. 'They sell medicine. It's supposed to help the—er—measurements. A lot of women have complained to us. They claim the medicine doesn't work.' One girl, who secured no results with twenty-one bottles of medicine, was subsequently sold hormone pills, in violation of the law, Williams said. Worse, he continued, the laboratory claimed falsely that its potions and their results were 'practically guaranteed' by the Board of Health. . . ." (San Francisco Examiner, August 3, 1940.)

"Dr. Doxey R. Wilson, 56, superintendent of the Santa Clara County Hospital, failed to appear in Santa Cruz police court yesterday for plea and preliminary examination on a morals charge. His \$1,000 cash bail, posted last Monday, was forfeited by Judge Paul Colegrove, when Police Chief Al Huntsman said Santa Cruz authorities were disinclined to prosecute further because Doctor Wilson is reported suffering from a mental breakdown and has entered a private sanitarium for examination and treatment. . . . Santa Clara County officials said that Doctor Wilson has not returned to the hospital since his arrest and that it is most unlikely he will ever resume service there. The resi-

(Continued on Page 42)

“CONGESTION DUE TO
SMOKING RETURNED
WITHIN ONE WEEK
in 80% of the cases, on chang-
ing back to cigarettes made
by the ordinary method!”

The information quoted is from tests reported in Laryngoscope*. While Philip Morris do not claim to cure irritation, here is what the tests revealed: *When smokers with irritation of the nose and throat due to smoking changed to Philip Morris, irritation cleared completely or measurably improved.*

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*Feb. 1935, Vol. XLV, No. 2, 149-154



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(Continued from Page 40)

dent physician is directing operations temporarily, they said, and the vacancy is not expected to be filled formally for several months. Hearing on the companion case against Carl Bloom, 26, resident of the SRA unemployed single men's camp at Soquel, was postponed a week by Judge Colegrove." (San Jose Mercury-Herald, August 8, 1940.)

"Anna Louise Jeffery of Nebraska was arrested July 30 on a violation of the Business and Professions Code, on complaint of C. A. Winkelman of the State Board of Pharmacy. Mrs. Jeffery was selling herbs and tonics, and had sold \$130 worth, most of them to people in Surprise Valley. Mrs. Jeffery claimed to be a sister of the Indian herb doc-

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tor, Conway, of Chico. District Attorney Lederer says, however, that in a check-up Conway denied this relationship. Mrs. Jeffery was also known as Anna Free. . . ." (Alturas Plain Dealer, August 3, 1940.)

Death of Theodore Weicker, Chairman of the Board, E. R. Squibb & Sons.—Theodore Weicker, who has been credited probably more than any of his contemporaries with helping to raise the pharmaceutical industry to its present standards, was born in Darmstadt, Germany, in 1861. His death occurred on August 8, 1940. Mr. Weicker spent his boyhood in that ancient city and was graduated from the "Realschule" at seventeen. On his graduation he joined the two-century old German house of E. Merck, advancing to an executive position in a few years.

In 1887 he sailed for New York to make his career. He immediately applied for citizenship, acquiring this status in the shortest time provided by law. At his insistence, the firm of Merck & Company, discarding a two-hundred-year-old tradition, established a branch in this country to take the place of the previous agency. Mr. Weicker became partner in the American enterprise and remained as managing partner of the New York branch of Merck & Company for fifteen years.

In New York, Mr. Weicker found time, despite the exacting demands of his business, to study at Columbia University and to acquire two degrees, graduating in Pharmacy and Pharmaceutical Chemistry. During this time he became intensely interested in the work of Dr. Edward R. Squibb, the founder of the House of Squibb.

Having prospered, Mr. Weicker, in 1905, following Doctor Squibb's death several years previously, joined with

(Continued on Page 44)



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HILTON MANAGEMENT

(Continued from Page 42)

the late Lowell M. Palmer, a leading capitalist, to buy and preserve the name of E. R. Squibb & Sons. At that time one bookkeeper took care of all the office work, one salesman handled all the direct contacts with the trade, and the laboratory had about one hundred employees. Squibb quality standards had been conscientiously developed and maintained, but the problem of expanding business as such has received scant attention. From the commercial point of view there was only a name.

Theodore Weicker, however, brought more than a keen commercial talent and business imagination to bear upon that name. . . . What he saw was an idealistic conception of policy and method, which would enable the company to carry to all the members of the professions it served, and to the general public as well, the benefits then available only to a professional few.

Appreciating the needs of mankind through a sympathetic observation, Mr. Weicker had been disturbed by the flood of nostrums and quack remedies on the American market. He boldly took the stand that generally existing commercial practices were a sign of ineffective management and limited vision. Step by step he built up the personnel of the laboratory, the production department, the sales force, the office staff and the organization generally.

He conceived the idea of extending to the general public, under strict professional supervision, information previously available only to a discerning few. Mr. Weicker proposed to reach this objective through general advertising, and he put forth an educational plan to make known to the broad public the name and ideals of his House through the advertising pages of the public press. Mr. Weicker directed this campaign personally, and as a part of it evolved its key—"The priceless ingredient of every product is the honor and integrity of its maker"—an advertising standard which

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became a classic in American business literature. The American Medical Association unreservedly endorsed this campaign as a distinct contribution to public education and to the best interests of the medical profession. It was to this ideal that Mr. Weicker had devoted his life.

In October, 1938, at New Brunswick, New Jersey, Mr. Weicker saw a lifelong dream come true. There, before a distinguished gathering of scientists and physicians, he threw open the doors of the new Squibb Institute for Medical Research. This million-dollar institute, dedicated to pure research with the object of relieving human suffering, is one of the finest establishments of its kind in the country.

Today, the House of Squibb, after thirty-five years of guidance by Mr. Weicker, is one of the largest and best-known firms in the pharmaceutical field—world-famous for the quality of its medicinal products.

Explains the Term "Muscle Bound."—Explaining the term "muscle bound," *Hygeia*, the health magazine, says that it is a descriptive but not a scientific term "popularly applied to an abnormal muscular development which may restrict quick and supple movements, especially of the arms and shoulders. When a muscle is used a great deal, it tends to become shorter and hence to produce a strong pull on weaker sets of opposing muscles, causing in certain cases some deformity. For example, the large muscles on the front of the chest may be so overdeveloped as to pull so strongly against the weaker muscles of the upper back that a "round shouldered" condition may develop.

Every hospitalized case of open tuberculosis in an employee reduces the possibility of a disabling infection in an industrial physician's plant.—Leroy U. Gardner, M. D., *Surg., Gyn. and Obs.*, February, 1939.



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Highly Active Vitamin K Substance.—Thyloquinone, 2-methyl-1, 4-naphthoquinone, a synthetic preparation of unsurpassed vitamin K activity, has been placed upon the market by E. R. Squibb & Sons, New York. Dissolved in corn oil, Thyloquinone is supplied in two forms for oral administration—as solution and in small capsules (Microcaps).

Ansbacher and Fernholz of the Squibb Institute for Medical Research were the first to demonstrate the high biologic activity of 2-methyl-1, 4-naphthoquinone. Later

reports from many different laboratories have confirmed their findings. The substance, for which the Squibb name is Thyloquinone, is more potent, more rapid in action and more economical than naturally occurring vitamin K₁ or K₂ or any concentrate of these vitamins.

The clinical indications for Thyloquinone are the same for vitamin K concentrate. The chief uses, which have had repeated confirmation, are:

1. To cure or prevent hemorrhage in obstructive jaundice, biliary fistula and liver insufficiency.

2. To prevent or treat hemorrhage in the newborn by administration to the expectant mother or to the infant immediately after birth. These will probably prove to be the most important indications for the use of Thyloquinone, since intracranial hemorrhage, which is one of the major causes of death among the newborn, seems undoubtedly to be the direct result of prolonged prothrombin clotting time.

In addition to the confirmed uses, Thyloquinone is indicated for the oral treatment of hemorrhage associated with subnormal blood prothrombin content due to vitamin K deficiency.

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The whole character of a society may be conditioned by the nature of the disease common to it, and the happiness and progress of its people will depend to no little degree upon the status of the medical sciences and on the extent to which they are employed for the public good.—Richard H. Shyrock, *Public Health Reviews*, March, 1940.

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Rare Case of Fungous Infection.—A unique and rare case of a fungous infection of the membrane enveloping the heart is cited by Henry Joachim, M. D., and Silik H. Polayes, M. D., Brooklyn, in *The Journal of the American Medical Association*.

The case is rare in that it is the first to be reported and also one in which a diagnosis was made during life. Its history of infection is unique because the fungous organism was accidentally self-injected by a morphine addict. The yeastlike fungus, *Monilia*, was found in the container in which the morphine was kept. The victim took no antiseptic precautions with the daily injections.

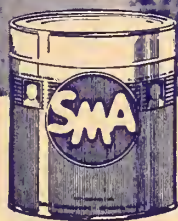
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Elhridge J. Best.....	San Francisco 1941	T. Henshaw Kelly.....	San Francisco 1942
Charles A. Dukes.....	Oakland 1941	E. T. Remmen.....	Glendale 1943
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Roy E. Thomas (Chairman).....	Los Angeles 1941	Frank J. Breslin, Secretary of Section on General Surgery, ex officio	
William Dock.....	San Francisco 1942	George H. Kress, Secretary of California Medical Association, (Chairman) ex officio	
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Committee on History and Obituaries		The Committee on Public Relations consists of the chairmen of the following standing committees and of certain general officers of the Association, all serving ex officio. The chairman of the committee is Donald Cass, the secretary is George H. Kress. The chairman of the Committee on Public Relations is ex officio a member of the Council.	
Frank R. Makinson (Chairman).....	Oakland 1941	Roy E. Thomas.....Chair., Com. on Health and Public Instruction	
J. Marion Read.....	San Francisco 1942	J. Norman O'Neill.....Chair., Com. on Hospitals, Dispensaries, Clinics	
Hyman Miller.....	Los Angeles 1943	Donald Cass.....Chair., Com. on Industrial Practice	
Secretary ex officio		George G. Reinle.....Chair., Com. on Medical Defense	
Editor ex officio		George D. Maner.....Chair., Com. on Membership and Organization	
Committee on Hospitals, Dispensaries and Clinics		John H. Graves.....Chair., Com. on Medical Economics	
George I. Dawson.....	Napa 1941	Junius B. Harris.....Chair., Com. on Public Policy and Legislation	
J. Norman O'Neill (Chairman).....	Los Angeles 1942	Charles A. Dukes.....Chair., Cancer Commission	
Benjamin W. Black.....	Oakland 1943	Dwight L. Wilbur.....Chair., Com. on Postgraduate Activities	
Committee on Industrial Practice		Harry H. Wilson.....President of California Medical Association	
Morton R. Gibbons.....	San Francisco 1941	Henry S. Rogers.....President-elect	
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George H. Sanderson.....	Stockton 1943	Communications for the Public Relations Department should be addressed to the Director, George H. Kress, M. D., Room 2004, 450 Sutter Street, San Francisco.	
Committee on Medical Defense		Cancer Commission	
George G. Reinle (Chairman).....	Oakland 1941	Orville N. Meland.....	Los Angeles 1941
William J. Van Den Berg.....	Sacramento 1942	A. Herman Zeller.....	Los Angeles 1941
Lewis T. Bullock.....	Los Angeles 1943	Gertrude Moore.....	Oakland 1941
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John H. Graves (Chairman).....	San Francisco 1941	Alson R. Kilgore.....	San Francisco 1942
L. W. Hines.....	Santa Rosa 1942	Henry J. Ullmann.....	Santa Barbara 1942
Edward C. Pallette.....	Los Angeles 1943	Charles A. Dukes (Chairman).....	Oakland 1943
Committee on Medical Education and Medical Institutions		Lyell C. Kinney (Vice-Chairman).....	San Diego 1943
B. O. Raulston.....	Los Angeles 1941	Otto H. Pfueger (Secretary).....	San Francisco 1943
L. R. Chandler (Chairman).....	San Francisco 1942	Communications for the Cancer Commission should be addressed to the Secretary, Otto H. Pfueger, M. D., 384 Post Street, San Francisco.	
Fred H. Kruse.....	San Francisco 1943	Committee on Postgraduate Activities	
Committee on Membership and Organization		F. E. Clough.....	San Bernardino 1941
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Dewey R. Powell.....	Stockton 1942	Dwight L. Wilbur (Chairman).....	San Francisco 1943
A. J. Cooper.....	San Diego 1943	Secretary ex officio	

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In connection with postgraduate and other studies, the packet library facilities of the larger medical libraries of California may be mentioned. Letters regarding literature, etc., may be addressed to the librarians of the following institutions:

(Continued on Page 5)

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(County society secretaries are requested to promptly notify "California and Western Medicine" when changes are indicated in their roster information.)

Alameda County Medical Association
2404 Broadway, Oakland
President, A. A. Alexander, 1904 Franklin Street, Oakland.
Secretary, Gertrude Moore, 2404 Broadway, Oakland.
Meeting, *Third Monday, 8:15 p. m., Hunter Hall, Oakland.*

Butte-Glenn County Medical Society
President, William W. Carey, 103 Hazel Street, Gridley.
Secretary, J. O. Chiapella, 131 Broadway, Chico.
Meeting, *Second Thursday.*

Contra Costa County Medical Society
President, Kaho Daily, 314 Tenth Street, Richmond.
Secretary, Clifford E. Dietderich, 1306 Pomona Avenue, Crockett.
Meeting, *Second Tuesday, 8:00 p. m.*

Fresno County Medical Society
President, Ray R. Dearborn, First National Bank Building, Madera.
Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, John N. Chain, Fourth and E Streets, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Lloyd S. Bambauer, 705 Home Street, Bishop.
Secretary, Clarence L. Scott, 609 Elm Street, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, C. S. Compton, 428 C Street, Bakersfield.
Secretary, Eric F. Colby, Hopkins Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
1925 Wilshire Boulevard, Los Angeles
President, Roy E. Thomas, 1136 W. Sixth Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
President, Bernard J. Conroy, Fairfax.
Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

Mendocino-Lake County Medical Society
President, Dallas L. Wagner, 615 Main Street, Fort Bragg.
Secretary, Royal Scudder, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, William E. Fountain, 557 Seventeenth Street, Merced.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Mast Wolfson, 215 Franklin Street, Monterey.
Secretary, Arnold Manor, 215 Franklin Street, Monterey.
Meeting, *First Thursday.*

Napa County Medical Society
President, Frank X. McGreane, Silverado Sanatorium, Calistoga.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

Orange County Medical Society
President, John A. Wood, 605 No. Los Angeles Street, Anaheim.
Secretary, Glenn Curtis, 323 North Pomona Street, Brea.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

Placer County Medical Society
President, William M. Miller, Auburn.
Secretary, Robert A. Peers, Colfax.
Meeting, *At Call of President.*

Riverside County Medical Society
President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, W. Philip Corr, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Norris R. Jones, M. D., 1127 Eleventh Street, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Walter S. Cherry, Rialto.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Joseph Weinberger, Medico-Dental Building, 233 A Street, San Diego.
Secretary, C. V. Bernardini, 1410 Medico-Dental Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, William Reilly, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Hugh J. Bolinger, Farmers and Merchants Bank Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. W. Yocom, 732 Thirteenth Street, Paso Robles.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Carl D. Benninghoven, Mills Memorial Hospital, San Mateo.
Secretary, Robert F. Monteith, 18 California Street, Redwood City.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Henry J. Profant, 1421 State Street, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
President, Merlin T.-R. Maynard, 241 East Santa Clara Street, San Jose.
Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.
Meeting, *Third Wednesday, 8:00 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. F. Giberson, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

Shasta County Medical Society
President, Clarence C. Gerrard, Redding.
Secretary, Bertram L. Trelstad, 1536 Market Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, Charles Pius, Yreka.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, H. Randall Madeley, 727 Sonoma Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

Sonoma County Medical Society
President, S. Z. Peoples, 159 Kentucky Street, Petaluma.
Secretary, T. E. Albers, 600 B Street, Santa Rosa.
Meeting, *Second Thursday.*

Stanislaus County Medical Society
President, Richard D. Husband, P. O. Box 709, Modesto.
Secretary, Hoyt R. Gant, 403 Beaty Building, Modesto.
Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

Tehama County Medical Society
President, H. H. Beck, Corning.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, Harry E. Barker, 1484 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Country Club.*

Yolo County Medical Society
President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Tuesday.*

Yuba-Sutter-Colusa County Medical Society
President, Ben F. Miller, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *First Tuesday.*

(Roster lists continued on advertising page 6)

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Barlow Medical Library (Los Angeles County Medical Association), 634 South Westlake, Los Angeles.

Nonprofit Hospitalization Corporations

In California, the three nonprofit hospitalization corporations named below are in operation:

Insurance Association of Approved Hospitals, 333 Pine Street, San Francisco; 675 East Santa Clara, San Jose; Easton Building, 428 Thirteenth Street, Oakland.

Associated Hospital Service of Southern California, 1151 South Broadway, Los Angeles.

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Lowell S. Goin, Los Angeles.....	(1940-1941)	Roy E. Thomas, Los Angeles.....	
Edward N. Ewer, Oakland.....	(1941-1942)	Frank R. Makinson, Oakland.....	
Edward M. Palette, Sr., Los Angeles.....	(1941-1942)	William H. Kiger, Los Angeles.....	
Robert A. Peers, Colfax.....	(1941-1942)	Frederick N. Scatenia, Sacramento.....	
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Nevada State Medical Association

President, C. W. West, Reno.	President-Elect, H. A. Paradis, Sparks.	Sec.-Treas., Horace J. Brown, Box 698, Reno.
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Miscellaneous California Medical Organizations

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San Francisco—State Office Building, McAllister and Larkin streets, UNDERHILL 8700.		San Francisco, Rm. 214, 515 Van Ness Ave.		Executive Secretary, Ben H. Read, San Francisco office, 244 Kearny Street, phone SUTTER 8470. Los Angeles office, Room 563, 1151 South Broadway, phone PROSPECT 5711.	
Sacramento—State Office Building, Tenth and L streets, CAPITAL 2800.		Los Angeles, 906 State Building.			
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California Northern District Medical Society		Southern California Medical Association		Headquarters Office: 1025 P Street, Sacramento; telephone Capitol 2800.	
President—John H. White, Chico.		President, John C. Ruddock, 1930 Wilshire Boulevard, Los Angeles.		Los Angeles Office: 1123 South Hill Street, telephone Richmond 4181.	
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TWENTY-FIVE YEARS AGO

(Continued from Text Page 200)

by the lay citizens; their part should be the contribution of necessary funds, whereas the portion of the physician is the contribution of his knowledge, his brains, his nerve force, his time and his physical energies—all of which overbalance anything the lay citizens may contribute. . . .

From an Original Article on "Nerve Injuries: Their Influence on the Period of Disability," by Thomas G. Inman, M. D., San Francisco.—In no other structure in the body, the vital organs excepted, is a wound of moderate degree accompanied by such marked and long continuing disability as that which results from division of one of the important nerve trunks. Regardless of the treatment employed, the return of normal function in the enervated parts must first be preceded by complete regeneration of the peripheral end of the nerve. There is no exception to this rule. Proper treatment, however, will do much toward confining the period of perverted function within the limits prescribed by nature, and the intelligent selection of that treatment depends upon the early recognition of the presence and nature of an injury and a correct interpretation of the physiological processes at work in a given case. . . .

From an Original Article on "The Relation of the So-Called Strained Back to Disability Following Industrial Accidents," by Sol Hyman, M. D., San Francisco.—The object of this communication is to help to convince the insurance companies through their physicians, that increase of expenditures in the original investigation of industrial accident cases will result in the saving of a far greater

(Continued on Page 9)

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TWENTY-FIVE YEARS AGO

(Continued from Page 7)

amount in both the compensation paid to the injured man, and in the cost of his medical attention.

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From an Original Article on "Traumatic Neuroses in Relation to Industrial Accidents; Prognosis and Treatment," by Walter F. Schaller, M.D., San Francisco.—The purpose of this paper is to touch upon some important issues concerned in the relation of the psychoneuroses to industrial accident, and particularly in relation to industrial accident compensation. The existence of functional nervous disease due to trauma is now well established, and it will not be necessary for me to make any argument before you, a representative body of physicians and surgeons, in favor of early recognition and diagnosis in cases of traumatic neuroses. Disability may begin with organic disease such as a fracture and continue as a psychoneurosis after the primary condition is cured. It is important then to mark the transition from organic to functional disease. The traumatic neuroses present definite clinical pictures and we divided

(Continued on Next Page)

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CALIFORNIA SANITARIUM For Treatment of Tuberculosis Belmont, California	GREENS' EYE HOSPITAL Consultation, Diagnosis and Treatment of Diseases of the Eye Bush and Octavia Streets, San Francisco	SAINT FRANCIS HOSPITAL Limited General Hospital Bush and Hyde Streets, San Francisco
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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

them under the headings of traumatic neurasthenia, traumatic hysteria, and traumatic psychasthenia. The symptomatology of these different divisions is the usual symptomatology of neurasthenia, hysteria and psychasthenia, the etiology being, of course, psychic shock usually accompanying some physical injury. . . .

From an Original Article on "Some Remarks on Industrial Insurance Work," by M. E. Rumwell, M. D., San Francisco.—The writer asks that these remarks be regarded as entirely informal, and not authoritative, and that any statements be regarded merely the outcome of a brief experience with the Medical Department of the Industrial Accident Commission of California.

The Workmen's Compensation, Insurance and Safety Act is a law and has been in force for nearly a year and a half, during which time the Medical Department of the Commission has gained many impressions and in some instances conclusions have been arrived at. These impressions have been modified from time to time, but the increased interest, more friendly attitude and the added coöperation of those medical men with whom it has come in contact has led this department to think at least some of its conclusions are along the right track. It is quite impossible to cover the whole field in a paper of this sort and it is simply in the spirit of endeavoring to present to your society some of these ideas as they exist at the present time, that this paper is offered.

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From an Original Article on "Internal Medicine in Relation to Industrial Accidents," by René Bine, M. D., San Francisco. . . . In the remarks that are to follow, it must be well borne in mind that the entire field under discussion is new to the large majority of California practitioners, and it must be realized that I am only attempting in a very sketchy way to point out the problems with which the internist is confronted when brought face to face with the Compensation Act, and, in doing this (however superficially), to stimulate all of you to better observation of cases in the future, so that when we have another symposium on this subject we may be able to throw more light on many of the difficult questions confronting us. . . .

From an Original Article on "Fracture Records: A National Effort Toward Standardization," by Thomas W. Huntington, M. D., San Francisco.—Recent legislation, both national and state, providing for industrial insurance and employer's liability, has a distinct and important bearing upon fracture treatment. No other class of injuries

presents so many phases which subject the person in charge and the result attained to so sharp criticism. As a consequence, an abrupt and imperative demand for clearly defined and fully recognized standards has been imposed upon all who are, directly or indirectly, responsible for fracture treatment and end results. . . .

From an Original Article on "The Use of Carbon Dioxid in Dermatology," by E. D. Lovejoy, M. D., Los Angeles.—Refrigeration in the treatment of skin conditions was first tried by Doctor White, of Boston, in 1899, the medium employed by him being liquid air. This has a temperature of -418°F ., is a bluish white, clear liquid and instantly freezes all tissues with which it is brought in contact. It undoubtedly was a valuable agent, but not being a commercial product, was very expensive and could not be kept for any length of time. Later, ethyl chloride and liquid carbonic acid spray were tried, but subsequently given up.

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From an Original Article on "The Relation of Certain Urinary Findings to Prognosis in Pulmonary Tuberculosis," by J. C. Cummings, M. D., Sacramento.—Definite rules for arriving at a correct prognosis in pulmonary tuberculosis are still lacking. Laboratory methods, so valuable in diagnosis, have hitherto been more or less useless as aids to prognostication. Some eight months ago articles by Weiss, Knock, Heflebower, Gwender, and Schaffle, discussing the prognostic value of Ehrlich's diazo reaction and the

(Continued on Page 22)

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BOOK REVIEWS

BOOKS RECEIVED

New and Nonofficial Remedies, 1940. Containing Descriptions of the Articles which State Accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1940. Cloth. Pp. 656-LXVIII. Price, \$1.50 postpaid. Chicago: American Medical Association, 1940.

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1939, with the Comments That Have Appeared in the Journal. Cloth. Pp. 205, with illustrations. Price, \$1. Chicago: American Medical Association, 1940.

Progress in Medicine. A Critical Review of the Last Hundred Years. By Iago Galdston, M.D. With a foreword by Henry E. Sigerist, M.D. Cloth. Pp. 347. Price, \$3. New York: Alfred A. Knopf, 1940.

Heart Failure. By Arthur M. Fishberg, M.D., Associate in Medicine, Mount Sinai Hospital, New York City. Second Edition, Thoroughly Revised. Cloth. Pp. 829, illustrated with twenty-five engravings. Price, \$8.50. Philadelphia: Lea & Febiger, 1940.

Pharmacology and Therapeutics. By Arthur R. Cushny, M.A., M.D., LL.D., F.R.S., Late Professor of Materia Medica and Pharmacology in the University of Edinburgh. Twelfth Edition, Thoroughly Revised. By C. W. Edmunds, A.B., M.D., Professor of Materia Medica and Therapeutics in the University of Michigan, Ann Arbor, Michigan, and

J. A. Gunn, M. A., M. D., D. Sc., F. R. C. P., Professor of Pharmacology and Director of the Nuffield Institute for Medical Research, University of Oxford, Oxford, England. Cloth. Pp. 852. Price, \$6.50. Philadelphia: Lea & Febiger, 1940.

Physical Diagnosis. By William Nance Anderson, B.Sc., M.D., Associate Clinical Professor of Medicine at the University of Southern California School of Medicine, Los Angeles, California. Cloth. Pp. 424, illustrated with ninety-two engravings. Price, \$4.75. Philadelphia: Lea & Febiger, 1940.

Management of the Cardiac Patient. By William G. Leaman, Jr., M.D., F.A.C.P., Assistant Professor of Medicine in Charge of the Department of Cardiology, Woman's Medical College of Pennsylvania, Philadelphia; Cardiologist, Woman's College Memorial, Northeastern Hospitals and Philadelphia Hospital for Contagious Diseases. Cloth. Pp. 705, with 255 original illustrations, two of which are in color. Price, \$6.50. Philadelphia: J. B. Lippincott Company, 1940.

Acute Infectious Diseases. A Handbook for Practitioners and Students. By J. D. Rolleston, M. A., M. D. (Oxon.), F.R.C.P. (Lond.), F.S.A., Formerly Medical Superintendent, Western Hospital, London; Editor British Journal of Children's Diseases, and G. W. Ronaldson, M. D. (Glasg.), D. P. H. (Oxon.), Medical Superintendent, South Eastern Hospital, London. Third Edition, Revised and Enlarged. Cloth. Pp. 477. Price, \$4.50. St. Louis: The C. V. Mosby Company, 1940.

Clinical Electrocardiography. By David Scherf, M.D., and Linn J. Boyd, M.D., F.A.C.P., Associate Clinical Professor of Medicine and Professor of Medicine, The New York Medical College, Flower and Fifth Avenue, Hospitals. Cloth. Pp. 362. Price, \$6.25. St. Louis: The C. V. Mosby Company, 1940.

A Textbook of Medicine. By American Authors. Edited by Russell L. Cecil, A.B., M.D., Sc.D., Professor of Clinical Medicine, Cornell University Medical College; Associate Attending Physician, New York and Bellevue Hospitals, New York City. Associate Editor for Diseases of the Nervous System, Foster Kennedy, M.D., F.R.S.E., Professor of Clinical Neurology, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician in Charge, Neurological Service, Bellevue Hospital; Consulting Physician, New York Neurological Institute. Fifth Edition, Revised and Entirely Reset. Cloth. Pp. 1744, illustrated. Price, \$9.50. Philadelphia: W. B. Saunders Company, 1940.

Physical Diagnosis. By Ralph H. Major, M.D., Professor of Medicine in the University of Kansas. Second Edition, Revised. Cloth. Pp. 464, with 437 illustrations. Price, \$5. Philadelphia: W. B. Saunders Company, 1940.

Byrd Health Attitude Scale. By Oliver E. Byrd, Ed. D., Associate Professor of Hygiene and Physical Education, Stanford University, California. Paper. Stanford University: Stanford University Press, 1940.

The New International Clinics. Original Contributions: Clinics; and Evaluated Reviews of Current Advances in the Medical Arts. Edited by George Morris Piersol, M.D., Professor of Medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia. Volume III, New Series Three, 1940. Cloth. Pp. 358. Philadelphia and New York: J. B. Lippincott Company, 1940.

Laboratory Text in Pharmacology. By Robert P. Walton, Professor of Pharmacology, School of Medicine, University of Mississippi. Paper. Pp. 85. Price, \$1.50. Philadelphia: J. B. Lippincott Company, 1940.

The Nursing Care of Patients With Infantile Paralysis. By Jessie L. Stevenson, R. N., Consultant in Orthopedic Nursing. Paper. Pp. 58. New York: The National Foundation for Infantile Paralysis, Inc., 1940.



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BOOK REVIEWS

Doctors in Shirt Sleeves. Musings on Hobbies, Meals, Patients, Sport and Philosophy. Edited by Sir Henry Bashford. Cloth. Pp. 294. Price, \$2.50. New York: Veritas Press, 1940.

This interesting volume edited by Sir Henry Bashford, lives up to its subhead, "Musings on Hobbies, Meals, Patients, Sport and Philosophy."

The twenty articles originally appeared in the *Lancet*. The score of stories from the pens of English physicians present an interesting sidelight on Britain's people. The character of the contributions may be judged by their titles: I. Crabbed Age and Youth; II. Some West Country Patients; III. From the Back Streets; IV. A Little Learning; V. The Life of a Surgeon; VI. Medical Students, Old and New Man, Nature's Baby; VII. Pity the Poor Physician; VIII. On Hobbies and Old Age; IX. In Praise of Dr. Rabelais; X. Too Much Prevention? XI. An Old Diary; XII. Some Thoughts on Meals and the Weather, and "Man, The Unknown"; XIII. Some Public School Memories; XIV. Some Forgotten Medical Journals; XV. Toys and Some Other Things;

XVI. The Biology of War, and a Word on the Modern Woman; XVII. Medicine and Philosophy; XVIII. Some Old Days in India; XIX. Science and Spiritual Values; XX. Retirement and a Garden.

The volume should be of particular interest to American physicians who desire to obtain somewhat an insight of the gracious philosophy that is so strong a characteristic of many of the practitioners of the healing art who make up the medical profession of Great Britain.

Arthritis and Allied Conditions. By Bernard I. Comroe, A. B., M. D., F. A. C. P., Instructor in Medicine, University of Pennsylvania; Ward Physician Hospital of the University of Pennsylvania. Cloth. Pp. 752, illustrated with 200 engravings. Price, \$8.50. Philadelphia: Lee & Febiger, 1940.

The author presents the difficult and ill defined subject of arthritis in a very interesting and readable manner.

The book contains short, concise tables stressing the important points in classification, history taking, physical examination, and laboratory procedures used in properly diagnosing joint disease. The subject of focal infection and its relation to arthritis is thoroughly discussed. The various forms of physiotherapy and measures for the prevention of deformities are well described and illustrated.

The author is conservative in his discussion on the use and value of the special forms of treatment for rheumatoid arthritis. He believes the gold salts are of definite value in selected cases but should be used with caution because of frequent severe reactions. The indications and contraindications are given in outline form.

The latter part of the book deals fairly completely with the diagnosis and treatment of such things as flat feet, back pain, and bursitis.—J. C. S.

Surgical Anatomy. By C. Latimer Callander, M. D., F. A. C. S., Associate Clinical Professor of Surgery and Topographic Anatomy, University of California Medical School; Member of Founders' Group of the American Board of Surgery; Member of American Association of Traumatic Surgery; Associate Visiting Surgeon to the San Francisco Hospital. With a Foreword by Dean Lewis, M. D., Sc. D., LL. D., F. A. C. S. Second Edition, Entirely Reset. Pp. 585, with 819 illustrations. Cloth, \$10 net. Philadelphia and London: W. B. Saunders Company, 1939.

The first edition of this text, appearing in 1933, is already well known to California surgeons, as surgical anatomies in general are infrequently produced, and the author is widely known and recognized throughout the State.

The second edition brings a definite improvement in that both the text and the number of illustrations have been reduced, the volume now containing 254 pages and 447 illustrations less than formerly. Of the 819 remaining illustrations, 100 of them are reported by the author to be new and most of them are original. Considerable text has been omitted, and in several instances new text has been added where such was needed for completeness and the incorporation of recent advances in the field of surgery.

Combined with the anatomy is a good deal of clinical material and surgical technique, the volume thus serving, in a way, as a source book for the handling of common surgical conditions.

The second edition of this already popular text will find its way into many a surgeon's library.—L. D. H.

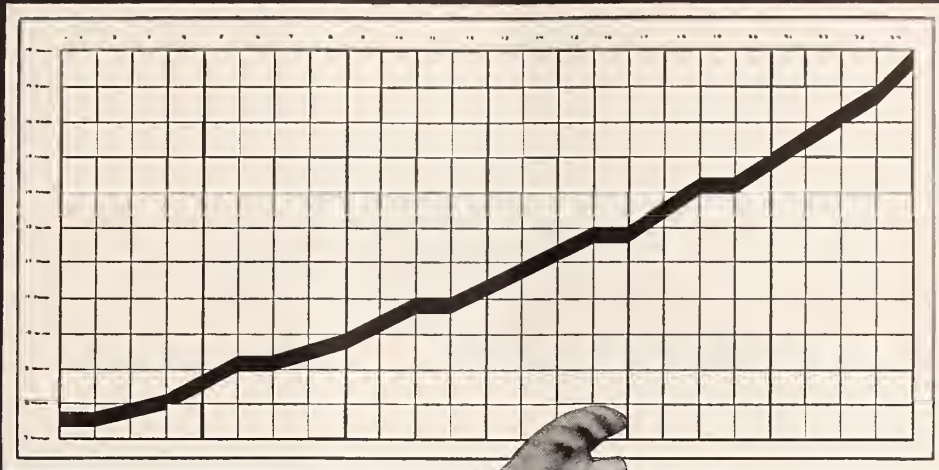
The Surgery of Injury and Plastic Repair. By Samuel Fomon, Ph. D., Formerly Major Medical Corps., United States Army. Cloth. Pp. 1409, illustrated. Price, \$15. Baltimore: The Williams & Wilkins Company, 1939.

The contents of this book might well be called a basic course for the surgery of injury and plastic repair. The first nine chapters are devoted to the care of the patient and the many necessary procedures that come in sequence as the case develops from the preparation of the patient, local as well as general, previous to operation down through the postoperative management. The author has consulted numerous references selected according to him as choice and select material from the most important, incorporating this into the text with numerous illustrations.

The next eleven chapters are devoted, chapter by chapter, to the special anatomical division of the body that the plastic surgeon constantly deals with, except reconstruction involving the external urogenital organs.

Each chapter is as complete as possible regarding all reconstructive phases of its subject matter. The author has

(Continued on Page 18)



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BOOK REVIEWS

(Continued from Page 16)

recorded and utilized his own findings, and freely abstracted from many articles of leading reconstruction surgeons throughout the world, of as many of the tried basic procedures as he possibly could. Numerous illustrations add greatly to the clarity of the book, particularly for those looking for aid in some of their plastic problems which might seem out of the ordinary.

One should be warned that everything quoted in this book is not gospel truth, that many procedures and illustrations have been recorded for the sake of completeness, but this may not necessarily prove to be the best method of repair, although in diagrams they may be perfect. At least this is the opinion of the reviewer.

All in all, this book represents a basic volume in the repair of injuries and has an excellent bibliography of most of the recent articles on the subject of plastic and reconstruction surgery.—G. B. O'C.

bismuth preparations for use in the treatment of syphilis; they are noteworthy in that sobisminol mass has been shown to be effective when used orally.

The status report on questions concerning vitamins compiled by the Coöperative Committee on Vitamins of the Councils on Pharmacy and Chemistry and on Foods is becoming an almost annual event, awaited for the revisions of the "Allowable Claims" found acceptable for the various vitamins. This year's revisions are not extensive but the report is noteworthy for the reëmphasis of the Council's stand on the subject of vitamins and vitamin mixtures. Alas, the Council's is but one clear, authoritative voice of rationality in today's whirlwind of polyvitamin and polyvitamin-mineral absurdities foisted on the gullible public by astute and sophisticated advertising technic.

The leadership of the Council in matters of endocrine therapeutics and nomenclature is well sustained.

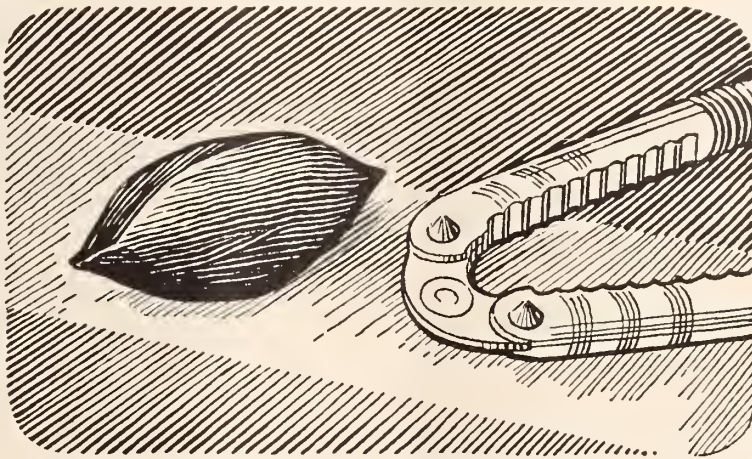
Three "special" reports are worthy of mention. One is the warning report on the dosages of intra-urethral injection of solutions of local anesthetics, a reaffirmative

(Continued on Page 20)

Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1939 with the Comments That Have Appeared in "The Journal." Cloth. Price, \$1. Pp. 205, with five illustrations. Chicago: American Medical Association, 1940.

Only seven of the thirty-five reports listed in this annual collected report are of the familiar "Not Acceptable" or condemnatory type. Two reports announce omission of products from N. N. R., one being off the market. The remainder, far superior in bulk as well as in number, are concerned with educational and constructive considerations. This trend has been noticeable in recent years; it reflects the great predominance of the constructive over what may be called the destructive side of the Council's work of promoting rational therapeutics.

The educational reports touch three fields on which lie the front lines of present-day therapeutics progress—chemotherapeutics, endocrines, and vitamins. Two reports on sulfa-pyridine deal with the status and Council acceptance of commercial brands. The report on Neoprontosil recognizes that term as the Winthrop Chemical Company's proprietary name for 4-sulfonamide benzene-2-azo-1-hydroxy-7-acetylamino naphthalene-3:6-disodium sulfonate, and azosulfamide as the nonproprietary name for the same substance. The articles on Dilantin Sodium, Sobisminol Mass, and Sobisminol Solution are status reports which accompanied the descriptions of accepted brands, a type of article increasingly used by the Council. Dilantin sodium is the new drug used in the treatment of epilepsy and has been accepted by the Council with carefully stated limitations for its use; sobisminol mass and sobisminol solution are new soluble



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BOOK REVIEWS

(Continued from Page 18)

strengthening of previous Council pronouncements. One is the Council statement Manganese in the Treatment of Dermatologic Disorders, which is buttressed by the conclusive and well documented paper by Dr. Maurice Sullivan, considered and sponsored by the Council. The third is the Study of the Promiscuous Use of the Barbiturates, Their Use in Suicides, a paper by Dr. W. E. Hambourger based on a review of medical literature and study of vital statistics. This study was authorized by the Board of Trustees of the American Medical Association and will be followed by other papers dealing with other aspects of the problem.

The present annual volume of Council reports is somewhat larger than usual and somewhat above the average issue in interest.

New and Nonofficial Remedies, 1940, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1940. Cloth. Price, postpaid, \$1.50. Pp. 656-lxviii. Chicago: American Medical Association, 1940.

Each year a revised list of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association as of January 1 is published in book form under the title of *New and Nonofficial Remedies*. The book contains the descriptions of acceptable proprietary substances and their preparations, proprietary

mixtures if they have originality or other important qualities, important nonproprietary nonofficial articles, simple pharmaceutical preparations, and other articles which require retention in the book.

A list of articles and brands accepted by the Council, but not described, is included in the book to cover simple preparations or mixtures of official articles (U. S. P. or N. F.) marketed under descriptive, nonproprietary names for which only established claims are made. Diagnostic reagents which are not used in or on the human body, and protein diagnostic preparations are not included in *New and Nonofficial Remedies* unless the determination of the status of these products by the Council has been requested by the distributor: If such products are found to be marketed in accordance with the Council's rules, they may be included in the list of undescribed, but acceptable articles.

New and Nonofficial Remedies is a practical and condensed text of pharmacology and therapeutics; it contains scientifically elaborated standards for all accepted non-official drugs; its Index to Distributors is a list of manufacturers, a large number of whose products have met the Council's high standards; its Bibliographical Index is a storehouse of references to reports which have been made mainly on unaccepted and unacceptable drugs; its prefatory material contains the Council's "Rules," a time-tested and reliable set of basic principles for the furtherance of scientific and rational medicine.

A supplement to the annual volume of *New and Non-official Remedies* is published twice a year to bring up to date such current revisions and additions as have been necessary since its last publication.

(Continued on Page 22)

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* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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BOOK REVIEWS

(Continued from Page 20)

The 1940 *New and Nonofficial Remedies*, of course, contains the revisions which appeared in the supplements for the 1939 edition, and continues the plan of grouping together articles having similar composition or action under a general discussion.

Noteworthy revisions are those of the chapter on Liver and Stomach Preparations, radically rewritten and including a statement of requirements suggested by findings of the Anti-Anemia Preparations Advisory Board of the U. S. Pharmacopeia; the subsection Tuberculin, entirely rewritten to conform to newer knowledge in this field; and the chapter Allergenic Protein Preparations, the name of which has been changed to Allergenic Preparations. Minor but relatively important revisions are found in the articles: Bismuth Compounds, Serums and Vaccines, and Vitamins and Vitamin Preparations for Prophylactic and Therapeutic Use.

TWENTY-FIVE YEARS AGO

(Continued from Page 11)

so-called urochromogen test with potassium permanganate in the urine of tuberculous subjects came to my attention. Weiss refers to his earlier writings on this subject, dating back to 1906, at which time he observed that death invariably followed the persistent presence of the diazo reaction in the urine of tuberculous subjects. . . .

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(Continued on Page 25)

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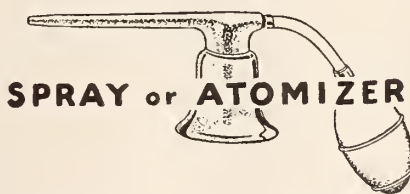
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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

. . . In August, 1914, the after-care work for the four northern state hospitals of California was established and a limited amount of time was given to the examination of new cases. Although no effort was made to advertise the fact that such a clinic was being conducted, one hundred cases have been presented for mental examination and advice during the past ten months. These patients were referred to the clinic by general practitioners, social workers and after-care patients. Two came from the city prison. The majority of the cases were referred by other clinics at the University Hospital to the nerve clinic, where neurological, and if indicated, serological and cytological examinations were made. . . .

From an Original Article on "Address of Welcome Delivered Before the Pacific Coast Oto-ophthalmological Society at San Francisco, California," by H. B. Graham, M. D., San Francisco.—. . . We welcome this association here because we think that it stands for a union of strong forces in the West that will help these sentiments along; that it stands for something else besides the reading of a scientific program and a pleasure jaunt. I believe that the sentiment of such an organization can be directed toward the accomplishment of large reforms along many lines throughout our glorious West; that the menace to the public from the spitting nuisance, the spittle on the street-car transfer and money, the drinking fountain and towel nuisance, unnecessary odor and noise nuisances, such as the clanging of bells, tooting of horns and the idiotic blowing of hideous sirens to tickle the vanity of some fat politician or hottentot potentate will be come things of the past through the personal effort of individual members of this association. . . .

From "Tuberculosis Fight in San Francisco."—At the last meeting of the Board of Directors of the San Francisco County Medical Society, it was voted, "that the San Francisco County Medical Society endorse the proposition of the San Francisco Association for the Study and Prevention of Tuberculosis, to have the city establish a special Bureau of Tuberculosis under the auspices of the San Francisco Board of Health."

This action by the physicians came as a result of the report recently made to the Department of Public Health by the Tuberculosis Association, revealing conditions in the city and urging that a division of the department be created to fight the "White Plague."

This bureau, according to the report, would establish clinics for free examination of positive and suspected cases; engage visiting nurses to care for and instruct patients and their families in the home, and take general charge of the campaign.

The Association reasons that tuberculosis is essentially a problem in public health and should be supported by public funds.

From So-Called New Antiseptic.—Recently the newspapers have contained announcements of a new antiseptic or germicide that has proved, or is to prove, of great value in the treatment of the wounded in the present war. Credit for its discovery is given to Doctors Carrel and Dakin.

The antiseptic referred to is that which Doctor Dakin of the Herter Laboratory, New York—now serving as bacteriologist in a war hospital at Compiègne in France—announced in a paper read before the Académie des Sciences in Paris. It is made by the well-known process of adding sodium carbonate to a solution of chlorinated lime. The mixture is thoroughly shaken, and after half an hour the

(Continued on Next Page)



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TWENTY-FIVE YEARS AGO

(Continued from Preceding Page)

liquid is siphoned off from the precipitate of calcium carbonate and filtered through cotton. To this clear liquid, sufficient boric acid is added to make the preparation neutral or acid, the amount required being determined by titration with phenolphthalein. Such a solution was found to kill pus germs in two hours. . . .

From "Restricted Practice for Drugless Practitioners." Under the pretext that they were "not practicing medicine," so-called drugless practitioners have prevailed on the legislators of several states to pass laws granting them the privilege of obtaining licenses to treat the sick under educational standards that are lower than are required of physicians. In the majority of these states the law does not permit such practitioners to practice surgery or to prescribe drugs; they are supposed to limit their practice to the use of the method or system of treatment advocated by the particular cult to which they belong. This arrangement, in which the public interests are forgotten, if not deliberately set aside, is indefensible from every point of view according to *The Journal of the American Medical Association*. It is class legislation, since it provides unequal standards for different groups of practitioners of the healing art. The limitation of practice is dangerous, since those who undertake to treat the sick should be acquainted with all methods of treatment and be free to use the one which meets the immediate needs of the patient—to save his life, if it is an emergency case, the prompt administration of a drug may be essential. . . .

From "California."—Our Medical Schools as described by the Council on Medical Education, *Journal A. M. A.*, August 21, 1915.

California population 2,757,895, has six medical colleges. Three are located in San Francisco, a city of 448,502 inhabitants. They are Leland Stanford Junior University School of Medicine, College of Medicine of the University of California and the College of Physicians and Surgeons. The College of Physicians and Surgeons, Medical Department of the University of Southern California, is situated in Los Angeles, population 438,914. The Oakland College of Medicine and Surgery is in Oakland, population 183,002. The College of Medical Evangelists is located at Loma Linda, a village of 110 people.

To secure license to practice medicine in California under the "physician's and surgeon's" certificate, students matriculating in medical colleges in and after a session of 1915-16, prior to such matriculation, must have completed at least one year of recognized collegiate work including college courses in physics, chemistry, biology and a modern language. This applies to all graduates of 1919 and thereafter.

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 200)

forces, and that another was killed in action with the Nazi armies in the Polish campaign. . . ." (*San Francisco Examiner*, August 14, 1940.)

"Dr. David Greenwood (Chiropractor), 1064 South Ninth Street, Alhambra, yesterday was sentenced to San Quentin prison for one to ten years following his plea of guilty to a charge of manslaughter. The physician (chiropractor) had been charged with the abortion-murder of Verna Marie Hendrix, eighteen, but was allowed to plead guilty to a lesser charge of manslaughter." (*Los Angeles News*, August 17, 1940.)

(Continued on Page 28)

STUDIES IN THE AVITAMINOSES



This page is the tenth of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the September 14 issue of The Journal of the American Medical Association.



Photograph courtesy of C. P. Rhoads, M. D., Memorial Hospital for the Treatment of Cancer and Allied Diseases, New York City.

The Dermatitis of PELLAGRA

The skin lesions of pellagra are considered one of the diagnostic signs; they are seen on the hands, neck, under the breasts, on the perineum, and on the legs. They usually are bilateral and are sharply demarcated from the surrounding normal skin. At first the involved area becomes erythematous and tender, resembling a mild sunburn. The skin is tense and swollen; itching and burning may be severe. At this stage vesicles or bullae frequently appear. After a period of weeks or months, the edema subsides, the erythema disappears, and the involved skin may assume a more normal appearance. Residual pigmentation persists, however, especially about the hair follicles.

The Glossitis of PELLAGRA

The glossitis of pellagra is usually among the early symptoms. It is manifested initially by hyperesthesia, which frequently develops before objective signs. As the deficiency state becomes more pronounced, desquamation of the superficial epithelium gives the tongue a beefy red, smooth, dry appearance. During desquamation, secondary infection with Vincent's organisms or Monilia frequently occurs, producing a thick white or yellow coating which ultimately is shed. The tongue becomes swollen, and fissures and aphthous ulcers develop on its surface. The inflammatory process spreads to the buccal mucosa, the gums, the lips and the pharynx, producing superficial ulcerations in these areas.



Illustration courtesy of Henry Field, Jr., University of Michigan Medical School, Ann Arbor.





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BOARD OF MEDICAL EXAMINERS

(Continued from Page 26)

"Charges of unprofessional conduct brought by the State Board of Medical Examiners under the old Medical Practice Act can be prosecuted under the Business and Professions Code, the District Court of Appeal ruled yesterday in reversing mandate proceeding halting the Board. Gifford L. Sobey, physician charged in the complaint, took the position that the legal effect of the adoption of the Business and Professions Code and the simultaneous repeal of the Medical Practice Act was to prohibit the institution, after August of 1937, of disciplinary proceedings against any offender where the offense charged was committed before that date. In answer to this contention, Presiding Judge Raymond E. Peters said: 'When a statute, although new in form, reenacts an older statute without substantial change, even though it repeals the older statute, the new statute is but a continuation of the old. There is no break in the continuous operation of the old statute, and no abatement of any of the legal consequences of acts done under the old statute.' In conclusion, Justice Peters said: 'We cannot believe that the Legislature was so solicitous of doctors who had violated their responsibilities to the public and who had been false to their trust, that it intended to abrogate all prosecutions for offenses committed prior to the codification of the law.' Justices Ward and Knight concurred in the ruling. Representing the medical board were Attorney-General Earl Warren and Harold W. Conklin, his deputy. The physician's attorneys were H. C. Lucas and Bradford M. Melvin. Appearing *amici curiæ* were Philbrick McCoy and Claude Minard for the State Board of California; Gerald H. Hagar, Fred B. Wood, Arthur McHenry on behalf of the California

Code Commission." (San Francisco Recorder, August 14, 1940.) (Previous entry, December, 1939.)

"Dr. Fred S. Ryan, fifty-eight, well-known San Jose physician and surgeon, was appointed acting superintendent and medical director of the Santa Clara County Hospital yesterday by the Board of Supervisors. He succeeds Dr. Doxey R. Wilson, who was at the same time granted an indefinite leave of absence without pay by the Board. Doctor Wilson is reported undergoing treatment at a private sanitarium. Doctor Ryan, whose appointment to the \$700 position was supported by the County Medical Association, is a native of North Dakota and a graduate of the University of California and of Northwestern University. He served in the Medical Corps in the last war. . . ." (San Jose Mercury-Herald, August 13, 1940.) (Prior entry, September, 1940.)

"An appeal by Dr. Nathan S. Housman from his conviction on three misdemeanor charges of failing to keep proper records of narcotic prescriptions was argued before the appellate department of San Francisco's Superior Court yesterday. The appeal was ordered submitted on briefs for decision." (San Francisco Chronicle, August 24, 1940.)

"The Board instructed the county executive and Assistant District Attorney William A. Green to prepare an ordinance, patterned after that in effect in the city of Sacramento, for the regulation of chiropodists operating in the rural areas of the county. The proposed ordinance would require chiropodists to operate in an office entirely sepa-

(Continued on Page 30)

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BOARD OF MEDICAL EXAMINERS

(Continued from Page 28)

rated from any other type of business and would prohibit a shoe clerk from trying boots, shoes or slippers on the feet of any customer unless stockings or socks were worn by the customer." (Sacramento *Bee*, August 26, 1940.)

"A Japanese, Fred M. Koba, who reportedly posed as a graduate of one of San Francisco's leading medical schools, was arrested yesterday on a charge of practicing medicine without a license. Koba was jailed on complaint of Joseph Williams, investigator for the State Board of Medical Examiners. Williams charged that Koba for more than a year treated another Japanese, who finally died." (San Francisco *Examiner*, September 6, 1940.)

"Dr. Thomas A. Storey, who worked with the Federal Home Health Board during the last war, is returning to the service of his Government in the United States Public Health Service. The emeritus head of the Stanford School of Physical Education and Hygiene leaves tomorrow for New York, where he will go on duty on October 1 as a member of a United States agency to control venereal diseases near army training stations and centers of national defense workers. . . . The work is not unfamiliar to Doctor Storey. He was loaned by the City College of New York to be executive secretary of the Inter-Departmental Social Hygiene Board, a body that fought venereal disease during the World War, and has made a specialized study of the subject for more than forty years. For many years Doctor Storey has been a member of the American Social Hygiene Association and was hired by the United

States Health Service to represent that association in the new program. He will be associated with Dr. William Freeman Snow, at one time California health commissioner and eminent worker in the control of social diseases. . . . The Stanford man will make his headquarters in New York, but expects to be sent to various parts of the country. . . ." Palo Alto *Times*, September 2, 1940.)

"Charged by the State Medical Board with violation of his probation, Dr. W. G. Cardew, seventy-two, chiropractor, was booked at the county jail yesterday. A bench warrant for the chiropractor's arrest was obtained in Judge Grandin H. Miller's court by Thomas P. Hunter, inspector for the medical board. Cardew had been fined \$100 and placed on two years' probation last April. A condition of his probation was nonpractice of medicine." (San Jose *Mercury-Herald*, September 5, 1940.) (Previous entry, June, 1940.)

"One cent is the fee most commonly charged for an ordinary call on the doctor in the little town of Angola on the west coast of Africa, Dr. R. B. Parsons, missionary, stated in his speech to members of the Kiwanis Club on Wednesday. A minor operation brings the fee of \$1, while a major surgical treatment may come as high as \$1.50, he stated. Doctor Parsons has recently returned from a nine-year stay in the country near the mouth of the Congo River and is substituting for a San Jacinto doctor, who is taking his annual vacation. . . ." (Hemet *News*, August 30, 1940.)

Special Agent Williams, in a report regarding the activities of Ben K. Glover (referred to in newspaper clippings
(Continued in Back Advertising Section, Page 34)

THE TRACE ELEMENTS IN BIOLOGICAL MATERIALS

● Students of nutrition recognize a total of some thirteen inorganic elements either as essential to humans or, in our present state of knowledge, as probably desirable for complete nutrition. For certain of these elements—definitely proven to be essential—reasonable estimates of the daily human requirements have been made. In addition, the distribution in common foods of minerals, especially those essential minerals most apt to be deficient in the diet, is well understood. Certainly, enough information appears to be at hand to insure an optimal supply for the individual of these essential or desirable elements through modern diet planning.

However, for many years it has been known that traces of elements, other than those known to be essential, may be present in animal and plant tissues (1, 2). Improvements in analytical techniques have been made and greater precautions observed in the handling of the materials used for analysis in studies reported within recent years. The results of these newer investigations have only served to confirm the fact observed in the older studies, namely, that "trace elements" may be present in biological materials, including mammalian tissues, along with the other elements recognized or accepted as essential in nutrition.

A fairly complete list of the trace elements includes silicon, aluminum, fluorine, nickel, arsenic, bromine, rubidium, barium, and selenium. The persistent occurrence of these elements in foods and in animal tissues logically raises two questions. First, are these elements essential in human nutrition, and second, assuming them to be essential, how might an adequate supply be obtained.

For the first of these two questions, there is as yet no conclusive answer (1, 2). Study of the possible part the trace elements may play in normal body functions comprises one of the frontiers of nutritional research. The fact that the trace elements are more or less consistently present in animal tissues is not necessarily conclusive proof of their essential character in nutrition; further research alone must decide that point.

The second of the above questions can be answered somewhat indirectly. It is not illogical to believe that we already recognize as essential those elements whose serious deficiency in the diet may produce the most serious irregularities in the human organism. Further, as stated above, the distribution of the known essential minerals in foods is well understood and by modern diet planning an adequate supply of these nutrients should be readily attained. It is not meant to imply that all of the trace elements are without significance in human nutrition, or that one essential nutrient is more important than another. Instead, it is intended to suggest that the distribution of all elements in foods is probably such that a protective diet—calculated to supply optimal amounts of all known essential minerals—should also supply the proper amounts of any unknown essential elements, as well.

Thus, the need for following the modern pattern of diet formulation is further indicated. The most practical means of insuring the needed quantities of all essential nutrients—recognized or as yet undiscovered—is to plan the ration according to the concepts and teachings of the modern science of nutrition. In pursuing the modern diet pattern (2), commercially canned foods should prove both valuable and convenient.

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REFERENCES

1. 1939. Mineral Metabolism, Alfred T. Shohl, Reinhold, New York.
2. 1939. Food and Life, Yearbook of Agriculture, U. S. Dept. Agri., U. S. Government Printing Office, Washington, D. C.

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CALIFORNIA AND WESTERN MEDICINE

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EDITOR GEORGE H. KRESS

Committee on Publications

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Francis E. Toomey	San Diego	1942
G. W. Walker	Fresno	1943
Secretary-Editor, ex officio		

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BUSINESS MANAGER GEORGE H. KRESS

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Change of Address.—Request for change of address should give both the old and the new address. No change in any address on the mailing list will be made until such change is requested by county secretaries or by the member concerned.

Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

MEDICAL PREPAREDNESS

Medical Preparedness Is Not an Imaginary Need.—Physicians who have been reading recent reports on the progress of Medical Preparedness—as outlined in the *Journal of the American Medical Association*, CALIFORNIA AND WESTERN MEDICINE, and other medical publications—must certainly and before now have come to the conclusion that the American Medical Association Committee on Medical Preparedness, working through the constituent state medical associations and they, in turn, through component county medical societies, is in deep earnest in its efforts to promote every measure that can assist the medical corps of the United States Army and Navy to meet, in fullest measure, their present and future obligations.

* * *

Significance of Medical Preparedness.—In all massive projects, such as that of Medical Preparedness for the United States, a beginning must be made somewhere.

Medical Preparedness—the term is used here in the broad sense of the highest type of service in both military and civil work, even though at the present moment the military phases seem paramount—deals primarily, as regards personnel, with licensed physicians and their professional qualifications. It becomes immediately evident, therefore, why accurate knowledge concerning physicians should be available to the constituted national authorities, upon whom will fall the task of selection of the medical men for specific types of service.

Keeping in mind the peaceful relations which the United States has maintained with other nations on the American continents, it is understandable why, at the present time, commanding officers and staffs of the medical corps of the Army and Navy do not have in their files in Washington, and elsewhere, much informative data concerning the 175,382 physicians licensed to practice in one or more states of the Union. California, for instance, according to the *American Medical Directory*, 1940 edition, has 11,909 physicians authorized to practice and care for the 6,873,688 citizens of the Golden State. Of this number of physicians, 6,507 are members of the California Medical Association.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

Action of the House of Delegates of the American Medical Association.—Shortly after the existing emergencies for an M-Day arose, the House of Delegates of the American Medical Association was in session in New York City, and that body instructed its officers to give prompt and fullest coöperation to the Surgeons General of the United States Army, Navy and Public Health Services, to the end that all needs of the Government might be adequately met. That is why the American Medical Association questionnaires were sent to every licensed physician in the United States, with a request that the information desired be forwarded promptly to the American Medical Association headquarters at 535 North Dearborn Street, Chicago. Unfortunately, the significance of the questionnaire was not sensed by many physicians. The California Medical Association will still send the necessary blanks to all requesting them, and physicians who have not mailed their questionnaires to Chicago are again urged to do so. California's record in this matter must eventually compare favorably with those of other state medical associations. At the time of this writing, however, it does not, for only about 54 per cent of California physicians have replied.

* * *

Important Meeting in Chicago on September 20.—On Friday, September 20, Doctor Philip K. Gilman of San Francisco, chairman of the California Committee on Medical Preparedness, and Doctor Charles A. Dukes of Oakland, a member of the American Medical Association committee, attended a meeting at Chicago at which representatives of the United States Army, Navy and Public Health Services explained the status of existing preparations, with special reference to plans for future needs. The *Journal of the American Medical Association* will no doubt print digests of the proceedings, and physicians who are interested should take the time to peruse the reports as they appear.

It has been estimated that it will be necessary to withdraw from civil practice, for service in the military arms of the Government, between five to ten thousand physicians, and it is the hope that this objective may be realized with a minimum of disturbance to civil needs, and a maximum of fulfillment in military objectives. The officers of the California Medical Association consequently urge all members to give wholehearted coöperation as needs may arise, by responding promptly to requests for information and work. Additional information concerning these activities is given on page 182.

COMPULSORY HEALTH INSURANCE: PROSPECTIVE REAPPEARANCE IN LEGISLATIVE SESSION OF JANUARY, 1941

A Recent Statement.—On page 107 of last month's issue, under the caption, "No Compulsory Health Initiative in 1940," CALIFORNIA AND WESTERN MEDICINE called attention to the fact that the threatened initiative for a compulsory health insurance law, to be voted on at the coming November election, had not materialized. But, as

repeatedly stated in editorial and other comments, the battle with proponents of a compulsory health insurance system for California is not over. No better evidence is needed for this conclusion than a broadcast by Governor Culbert L. Olson, so recent as October 1 and reported in the press, in which he said: "I should like to hope that the next legislature would tackle the problem of health insurance."

* * *

A Compulsory Health Bill Will Probably Be Submitted to the Next Legislature.—In the legislature of 1939, the State Administration submitted a compulsory health insurance plan that was publicized as one of its "must pass" measures. The proposed statute did not pass, but that does not mean that the sponsors of such a law have given up hope of its enactment in the near future.

Wherefore, it behooves members of the medical profession to acquaint themselves with the attitude, concerning public health problems, of candidates who seek election to the California Senate and Assembly. Only those aspirants for office whose past records indicate that they are in harmony with measures that make for the advancement of scientific medicine should receive the support of physicians.

OFFICIAL JOURNAL REPORTS BY COMPONENT COUNTY SOCIETIES: CHANGE IN PROCEDURE

Lesser Size of the Official Journal Creates New Conditions.—The lesser size of CALIFORNIA AND WESTERN MEDICINE—made necessary in order to lessen printing expenses—has led the Committee on Publications to consider how best to maintain the various departments of the OFFICIAL JOURNAL without materially reducing its informative text. At a recent meeting of the Committee the department for county society letters was carefully considered, and after discussion the conclusion was reached that the space heretofore devoted to county society letters from only a very few of the forty component county units could be made to bring a larger and better return to the Association if, in lieu of a few letters from a limited group, more comprehensive reports on a year's work from each of the forty societies were printed in December issues.

To attain this end, suggestive forms will be sent, in due course, to all county societies. Under the present system the State Officers and the headquarter's office have only sparse information concerning the activities of many of the component units. With proper coöperation, it is believed the factual data desired and actually needed could be made to be of greater value to all Association officers, while the recital of achievements by vigorous county societies would be of suggestive service and have a more stimulating effect for component units whose members were missing some of their opportunities for broader service. The indulgence of county societies, therefore, which in the past have sent in monthly letters, is requested until the new plan has been given a trial. At the same time, thanks are rendered for coöperation already given.

EDUCATIONAL NUMBER OF THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION

Issue of August 31.—Every year the *Journal of the American Medical Association* places before the medical profession of the United States one of its weekly issues, labeled with the special caption, "Educational Number." The informative data concerning medical education in the United States presented therein is little less than encyclopedic in its scope, with the advantage of terseness and exactness in text and tables, made doubly necessary by demands on the *Journal's* space. Members of the California Medical Association who failed to scan the pages of statistical facts and explanatory text, as given in the Educational Number of August 31, should take time to at least check on California or home state figures, school of graduation and other information of interest.

Two features or chapters are especially commended:

1. Continuation Courses for Practicing Physicians—Clinical Conferences, Graduate Assemblies and Interim Courses; and
2. Approved Examining Boards in Medical Specialties.

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Postgraduate Activities.—The paragraphs and tables dealing with Continuation and Clinical Courses reveal how important postgraduate work is construed to be by other state medical associations, and indicate how, in other commonwealths, state agencies and medical schools have found it possible to join with constituent state medical associations and local societies in developing an increasing interest in follow-up courses for physicians who are in private practice.

The need of every physician remaining alert to the rapid advances in scientific medicine has been so often emphasized that it is no longer necessary to discuss that phase. It must be apparent to all who ponder on the modern methods in medical practice that members of the healing-art guild who do not make an effort to keep abreast of the newer researches, knowledge and procedures, almost invariably lay for themselves a foundation for retrogression in both methods of practice, and in lesser number and less desirable kinds of patients. A heavy price to pay for indifference to advances in scientific medicine!

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Statistical Comparisons.—In making comparisons on what this, that or the other state is doing in continuation courses for physicians in practice, it is necessary to take into account many factors, such as size of the state, distribution of its population, ease of intercommunication, agricultural, industrial, economic, social welfare and other conditions. In California, for instance,* Alpine is a constituent county unit covering a geographical area of 770 square miles with a population of 319, and not a single physician in the county. Another example: Mono covers 3,030 square miles, with a population of 2,283, and has one Doctor of Medicine residing within its confines.

* See table in CALIFORNIA AND WESTERN MEDICINE, September, 1940, page 148.

In California's fifty-eight counties, with the 1940 census population of 6,873,688 human beings, other examples might be cited, the same being of special interest, since some of these counties are also in the lists of counties in the United States, so often quoted as not being supplied with a single physician.

Be it said, however, to the great credit of the members of the medical profession in some of the sparsely settled counties of California, that they are alert to the advances in modern-day practice and meet their manifold responsibilities in splendid manner, in spite of comparative professional isolation. That, though, does not lessen the responsibility of carrying to them and also to many physicians in what might be termed isolated districts located in metropolitan areas, the message and opportunity for further advancement in medical practice.

* * *

How May Continuation Courses Be Instituted?—How, then, it may be asked, is this real task to be accomplished? The answer is, through recognition by officers of the district and county medical societies in California of their responsibilities in doing their part to make available to the physicians in their communities the courses offered by the California Medical Association Committee on Postgraduate Activities. California's record in postgraduate or continuation courses will not be up to standard until such time as, in every part of California, it will be possible for every physician to attend, once or twice yearly, a clinical conference or follow-up course of one or more days' duration.

The State Association Committee stands ready to coöperate with every local unit that desires such work, and will do its utmost to aid in the selection of topics of interest and of guest speakers whose talks would have practical and other value. If local officers are tardy or reluctant in taking up this much needed activity, correspondence is invited from individual members. The State Committee seeks to know who are the physicians in the various communities who desire continuation or refresher courses; for with groups of interested colleagues, the work can then be instituted.

Letters to the Association Secretary, who acts also in secretarial relationship to the California Medical Association Committee on Postgraduate Activities, will receive prompt attention.

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Examination for Certification in One of the Specialties.—Reference was also made in the American Medical Association Educational Number to the national "Approved Examining Boards in Medical Specialties," of which there are fifteen, as follows:

- American Board of Anesthesiology
- American Board of Dermatology and Syphilology
- American Board of Internal Medicine
- American Board of Obstetrics and Gynecology
- American Board of Ophthalmology
- American Board of Orthopedic Surgery
- American Board of Otolaryngology
- American Board of Pathology
- American Board of Pediatrics

American Board of Psychiatry and Neurology
 American Board of Radiology
 American Board of Surgery
 American Board of Urology
 American Board of Plastic Surgery
 American Board of Neurological Surgery

Detailed information concerning history, personnel, purposes, qualifications for eligibility to certification, examinations, fees, etc., are given for each of the boards mentioned in the *Journal of the American Medical Association* for August 31. Younger members of the profession, who may have in mind ultimate transfer from general to special practice, are urged to read the provisions laid down for the specialties with which, at some future time, they aspire to associate themselves. The ambition of physicians to prepare themselves to do work in which they have a special interest, and according to the best standards, is always laudable, and the continued study for such an objective makes for keenness of perception in both general and special practice.

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These brief comments on two of the features in the Educational Number of the *Journal of the American Medical Association* should indicate why all readers who failed to notice that special issue, should take time to look it over. The factual data presented are as true and pertinent today as when given their initial presentation in the issue of August 31.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 180.

EDITORIAL COMMENT†

VIRUCIDAL ENZYMES IN NASAL SECRETIONS

Burnet, Lush, and Jackson¹ of Melbourne, Australia, report the discovery of a highly specialized virus-inactivating enzyme in human nasal secretions. Since this enzyme is particularly active against influenza virus, their discovery may conceivably pave the way to an effective clinical control of this disease.

That mucous surfaces are self-sterilizing has long been the opinion of clinicians. The earlier immunologists would account for this sterilization as the result of mechanical cleansing, plus the inhibiting action of traces of humoral antibodies and of lysins set free by disintegrating leukocytes. The first definite proof of a new type of chemical de-

fenses on mucous membranes was the discovery and isolation of the Fleming "lysozyme." Although this relatively simple chemical substance was found to be practically inactive against pathogenic bacteria, it did cause an immediate disintegration of certain nonpathogenic forms (*M. lysodeikticus*). Dold and Weigmann² afterward demonstrated other nasal (or salivary) "inhibins," active against diphtheria bacilli. The occasional presence of poliomyelitis-inactivating substances was subsequently reported by Howitt.³

The Australian investigators perfected methods of obtaining undiluted nasal secretions in relatively large volumes. A roll of gauze or absorbent cotton was pushed well up into each nostril and withdrawn at the end of thirty to sixty minutes. From each well-soaked plug about one cubic centimeter of nasal secretion could be wrung out by means of artery forceps. Pooled secretions were centrifuged and sterilized by filtration through a gradocol membrane.

Filtered exudates thus prepared were found to inactivate all strains of the influenza virus thus far tested, the reaction reaching a maximum after two hours' incubation at body temperature. The reaction was inhibited at low temperature. The active agent was destroyed by boiling. Many other viruses were tested and found to be wholly unaffected by the filtered secretion. These refractory viruses included: vaccinia, fowl-pox, rabbit myxomatosis, ectromelia of mice, infectious laryngotracheitis of fowls, and pseudorabies. Very slight virucidal effects were demonstrable with psittacosis, poliomyelitis and Rous sarcoma viruses. Well-marked antiseptic action was demonstrable against herpes, louping ill and virus B. Bacteriophages were wholly unaffected by the nasal secretions.

From available chemical evidence Burnet and his coworkers conclude that the virus-inactivating agent is not identical with lysozyme, or any other nasal antiseptic thus far studied. They believe that the virucide is a highly specialized enzyme, relatively specific for a narrow group of viruses. Whether or not the Burnet enzyme plays a significant rôle in the epidemiology of influenza is now the subject of statistical study. Attempts to isolate and identify the enzyme are also in progress.

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ATYPICAL CORONARY OCCLUSION*

In recent years interest in coronary thrombosis has been stimulated by the increased incidence reported within the medical profession as well as among the laity. In our minds, sudden closure of a coronary artery generally elicits a picture of severe chest pain or prolonged substernal oppression. Yet it has been established that painless plugging of a coronary artery does occur when even a large artery is involved.

² Dold, H., and Weigmann, F.: *Ztschr. Hyg. Infektionskr.*, 116: 158, 1934.

³ Howitt, B. F., *J. Infect. Dis.*, 60: 113, 1937.

* Condensed from paper read before the Los Angeles Heart Association, February 14, 1940.

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Burnet, F. M., Lush, Dora, and Jackson, A. V.: *Brit. J. Exper. Path.*, 20: 377, (Oct.), 1939.

In the series of cases published by Davis,¹ approximately 40 per cent were asymptomatic or without a history of pain. The mechanism generally agreed upon is that certain areas of the heart are not only less vital than others, but also less sensitive. But even if not relatively insensitive, they may become so by sclerotic processes occurring in the artery with concomitant fibrotic changes in the myocardium. Upon ageing, the scar tissue contracts obliterating vessels, myocardial fibres and nerves—virtually an auto-anesthetization.

In the recently published studies of Blumgart² and coworkers, it is concluded that the syndrome is not always associated with prolonged substernal oppression or severe chest pain, symptoms which usually bear a direct relationship to the degree of myocardial ischemia. When the narrowing of the artery has been sufficiently gradual to permit the development of a compensatory collateral circulation, a final occlusion may be likewise asymptomatic.

Diagnostic difficulty may be minimized by keeping in mind certain pain equivalents expressed in terms of sudden failure of the left ventricle. The pain equivalents are the *immediate* symptoms and signs of acute heart failure including dyspnea, shock, cyanosis or ashen pallor, pulmonary edema and other features of acute cardiac failure.

The *delayed* signs and sequelae are similar to those found in typical occlusion with moderate fever, leukocytosis, increased erythrocyte sedimentation rate, pericardial friction rub, embolic phenomena, various arrhythmias, tachycardias and, finally, the distinguishing electrocardiographic changes.

In brief, atypical coronary occlusion is to be suspected in sudden failure of the left ventricle with acute pulmonary edema. There appears to be, furthermore, a direct correlation between the symptomatology as well as prognosis and the adequacy of the compensatory collateral circulation.

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DANISH TECHNIQUE OF ACTIVE-PASSIVE DIPHTHERIA PROPHYLAXIS

Fjord-Nielsen¹ of the State Serum Institute, Copenhagen, Denmark, currently reports that, with a proper time interval between serum and toxoid injection, a superimposed active-passive diphtheria immunity is clinically possible.

The theoretical possibility of simultaneously immunizing laboratory animals by injecting a mixture of antiserum and homologous toxin was quite effectively ruled out by Th. Smith² and other early investigators. In their hands such a mixture is less effective than antitoxin alone, and does not stimulate a later production of active immunity. Nor was combined immunization possible if the serum and toxin were injected separately. Apparently

the specific toxin and antitoxin unite to form a nondissociable toxin-antitoxin complex, therapeutically and immunologically inert.

Following recent studies of bacterial toxoids, this early clinical hope has been revived. It is conceivable that toxoids precipitated with aluminum or aluminum hydroxid, for example, might form a dissociable and, therefore, immunologically active complex with homologous antitoxin. If so, a simultaneous injection of specific antiserum and homologous aluminum toxoid might cause an immediate passive immunity, gradually changing into a relatively permanent active immunity. About three years ago this conception was confirmed by Schmidt-Burbach³ and his coworkers of Berlin, Germany. In their technique, guinea pigs were given antidiphtheric serum intramuscularly, with a simultaneous injection of diphtheria aluminum toxoid subcutaneously. They obtained an immediate passive antitoxic immunity which gradually decreased till the eighth day, when measurable amounts of autogenous antitoxin began to appear in the circulation. This secondary autogenous immunity reached its maximum in about thirty days, and remained at a fairly high level for several months. Over four thousand school children were subsequently tested by the new technique, with statistical results not yet published by the Nazi clinicians.

This new "blitzimmunity," however, was immediately challenged by Frey and Schmid⁴ of Vienna, who injected twenty children simultaneously with diphtheria antitoxin and alum-toxoid. The Austrian clinicians found no demonstrable autogenous antitoxin in these children on the twenty-eighth day. In their hands the suggested method was less effective than routine antitoxin therapy, since one of their patients developed diphtheria during the course of the attempted duplex immunization. A similar challenge was reported by Gundel and König,⁵ who found that a combined active-passive immunity is only occasionally possible in laboratory animals, and then only if a proper quantitative balance is maintained between injected antiserum and toxoid doses. They found so many individual variations in this quantitative relationship, however, as to render duplex "blitzimmunization" impractical in clinical medicine.

Fjord-Nielsen, however, alleges that the duplex method may be rendered clinically feasible by interposing a three- to seven-day time interval between antitoxin and toxoid injection. Even with a time interval as short as three days, a prophylactically adequate autogenous immunity may develop. With the recommended seven-day time interval, antitoxin formation is equal to that in control animals. The possible clinical value of the new duplex technique was under investigation at the time of the Nazi invasion of Denmark.

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¹ Davis III, N. S.: Coronary Thrombosis Without Pain, J. A. M. A., 98:1806 (May 21), 1932.

² Blumgart, H. L., Schlesinger, M. J., and Davis, David: Studies on the Relation of the Clinical Manifestations of Angina Pectoris, Coronary Thrombosis and Myocardial Infarction to the Pathologic Findings, Am. Heart Jour., 19:1-91 (Jan.), 1940.

³ Fjord-Nielsen, I.: Ztschr. f. Immunitätsforsch., 97:306 (Jan.), 1940.

² Smith, Th.: J. Exp. Med., 11:241, 1909.

³ Schmidt-Burbach, A., and Dehmel, H.: Zentralbl. f. Bakt., 140:237, 1937.

⁴ Frey, L., and Schmid, E.: Ztschr. f. Immunitätsforsch., 95:486, 1939.

⁵ Gundel, M., and König, F.: Ztschr. f. Immunitätsforsch., 92:235, 1938.

ORIGINAL ARTICLES

OBESITY*

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AND

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OCCASIONALLY the medical profession hears of a new disease, but certainly obesity is as old as man. Christie has stated that as far as he knows, the first man to teach the world that obesity is a curable affliction lived in Paddington, England. His name was Banting, and he was employed by St. Mary's Hospital as an undertaker. So little was obesity considered a medical disease in those days that this undertaker took it on himself to address to the people "an open letter on corpulence," in which he extolled the method by which he himself had lost "2.5 stone," and had been converted, from a man who could not tie his own shoes or walk downstairs other than backwards, into a comfortable elderly gentleman.

ON TENDENCY TO OBESITY

Presumably, ever since there have been fat people, there have been those who say: "I get fat even if I don't eat a thing." One of the discussers of Doctor Sansum's paper made the statement that a patient could live on 400 calories a day and still remain obese. Can this be true? In other words, is it possible for anyone to remain obese when the calorie intake is markedly restricted? This type of discussion raises the question as to whether there are different types of obesity. Any number of classifications have been suggested^{16, 26} which imply that endogenous or "endocrine" obesity is a separate disease from the exogenous obesity which results simply from overeating.

There is, of course, no question but that certain individuals are "preordained" (to borrow a Presbyterian term) to one type of body architecture or another. Gurney listed evidence to suggest that obesity follows the Mendelian law. Ward stated: "The tendency of obesity to run in families has been definitely shown by the statistics of various writers, particularly Bauer's series which showed 88 per cent, and von Noorden's, 70 per cent, with a family history of obesity. Furthermore, Danforth reported a strain of yellow mice in which the tendency to obesity was transmitted as a unit character. Gurney's study of obesity showed 82 per cent of obese cases with one or both parents overweight. In his opinion, the inheritance of obesity is along Mendelian lines. Bauer found that only 2.6 per cent of a series of 275 obese patients showed an endocrine disturbance."

RÔLE OF ENDOCRINE GLANDS

There is no good evidence to incriminate the endocrine glands in most of the cases of obesity. Body

weight varies markedly with different diseases (Dunlop) and it is true that obesity is a part of the clinical picture produced by certain disturbances of the endocrine glands. But why should so much attention be given to the possibility of hypothyroidism as the cause of obesity when so few patients with true myxedema are obese? As a matter of fact, where the edema is lost, most myxedematous patients are thin! It is true that patients suffering from certain types of "hypopituitarism" are obese, but let us not forget that in Simmonds' disease, due to complete "hypopituitarism," the patients are extremely cachectic.

GREENE'S OBSERVATIONS

Greene studied 350 cases of obesity, 100 cases of chronic encephalitis, twenty-four cases of myxedema, twenty-two cases of pituitary tumor, five cases of suprasellar tumor and seven cases of diabetes insipidus. Low caloric diets were known to be employed for an adequate period of time by 146 of these patients, and all of them lost body weight satisfactorily. Greene emphasized the importance of appetite, exercise and other factors in the production of obesity and gave consideration to the fact that some types of pituitary disturbances are supposed to be responsible for obesity, whereas others are responsible for cachexia. One of his concluding statements was as follows: "It is difficult to detect any difference between the obesity which develops in association with long inactivity due to a fractured leg and that which develops with a long illness due to pituitary tumor, supracellar tumor, chronic encephalitis or myxedema. One has to admit, however, that not all patients with fractured leg and so forth become obese but neither do all cases of myxedema, pituitary tumor and chronic encephalitis." Bruch studied in detail the growth and maturation of 132 obese children from two to thirteen years of age and compared them with normal children. She felt that in many instances the obesity was a manifestation of early maturation.

Such a discussion could be endless. Can anyone deny the truth of the statement that the only source of fat is food? It is impossible to disregard the important observations of workers in the field of metabolism such as Liberson, DuBois, Grafe, von Noorden and Means.^{33, 34} Careful evaluation of the work done by these men gives added weight to the concept that all obesity is due to an increased intake of food and that man must follow the laws of energy exchange.

STRANG'S CONCLUSIONS

Strang drew the following conclusions: "(1) The exchange of energy in the obese, when compared to what would be normal for them if on proper weight, is increased. (2) This increase in exchange of energy is of the same magnitude as of the surface area increase beyond that normal for them. (3) When obese patients are reduced by dietary measures alone, the exchange of energy diminishes proportionately much more than the weight or surface area. (4) In spite of this drop in basal calories the metabolism never goes below limits normal for proper weight. (5) This observation contrasts

* Read before the Second General Meeting at the sixtieth annual session of the California Medical Association, Coronado, May 6-9, 1940.

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strikingly with the extreme energy economy in the individual of normal weight who is reducing by diet, as is shown by comparison with Benedict's figures. (6) There is, therefore, no evidence of an energy economy in the obese."

OTHER OPINIONS

Lyon stated: "All cases, whatever their origin, have this in common, that the excessive storage of fat is only possible if the intake of food is greater than the amount metabolized. Capital can only be accumulated if income exceeds expenditure."

Newburgh and Johnston stated: "Obesity is always caused by an overabundant inflow of energy. The excess is deposited as adipose tissue. This disproportion arises from a variety of conditions that may be thought of under two general headings. The first group includes the various human weaknesses such as overindulgence and ignorance. The second group is composed of conditions that cause a decrease in the requirement for energy; such as lessened activity or lowering of the basal metabolic rate for any reason. If the long established food habits do not respond to this lessened demand, obesity is inevitable."

RELATIONSHIP OF OBESITY TO OTHER DISEASES

The relationship of obesity to other diseases has been emphasized by many authors. Joslin has long emphasized the important relationship between diabetes mellitus and obesity. He stated: "The chief constitutional feature in the onset of diabetes is overweight. Among 4,599 patients, 78.5 per cent of the males and 83.3 per cent of the females were overweight at the time of their maximal weight. In contrast with these figures, only 7.9 per cent of the men and 6.3 per cent of the women had always been underweight." Goodrich and Fetter and associates have also commented on this important relationship. Musser called attention to the coexistence of hypertension, obesity and hyperglycemia and reported that with reduction in weight there was a lowering of the blood pressure and a return of the sugar tolerance curve to normal. Newburgh and associates^{37, 40} raised the question as to whether mild hyperglycemia and glycosuria in obese, middle-aged individuals is true diabetes mellitus. They reported interesting observations in which all of findings of diabetes mellitus have disappeared following reduction of weight.

Other diseases are known to be associated with obesity. Master and Oppenheimer found hypertension in 67 per cent of the cases of obesity and observed a corresponding fall in blood pressure as the patient's weight-curve dropped. They found changes both on roentgenograms and electrocardiograms which suggested a distinct circulatory embarrassment in obese individuals. Walker stated: "Obesity is a menace by tending to promote diabetes mellitus, hypertension, cardiac failure, cholelithiasis, varicosities, sterility, arthritis, sweating, faulty gait, faulty posture, hernia, and by increasing the risks and difficulties during any operation." Beck and Hubbard have studied the blood pressure, sugar tolerance curve, and so forth of sixty-three patients before and after reduction of weight. Bauman gave the percentage ratio on actual to ex-

TABLE 1.—Percentage Ratio of Actual to Expected Deaths

Sex	Overweight, Pounds	Ratio, Per Cent
Men	5 to 10	100
	15 to 20	116
	25 to 45	127
	50 to 80	153
Women	15 to 30	119
	35 to 60	124

pected deaths for men and women who were overweight, between forty and sixty-two years of age, based on 744,672 life insurance policies as listed in Table 1.

IMPORTANCE OF DIET

The importance of diet in treating obesity has been repeatedly described.^{7, 29, 36, 43, 48} There is no evidence to indicate that any obese patient will fail to lose weight if he follows a diet which is planned to furnish less calories than are necessary for his normal caloric requirements. The reasons for most failures are either that the prescribed diet contains too many calories or that the patient is not following the diet.

A very interesting part of Doctor Newburgh's³⁶ paper is the account of a dialogue between a physician and a very obese high school girl who stated that she "didn't eat a thing." Before the dialogue was completed, several thousand calories had been accounted for. Doctor Tunbridge has this to say about eating between meals: "One can never rely on the patient's opening remarks concerning his daily diet. Very few people will admit to overeating. How often have you been told: 'Doctor, I am a poor eater.' There are two very obvious fallacies to this statement. First, obese patients are often very self-conscious of their overweight and, in consequence, eat little at meal-times, but between meals they are always nibbling. When one realizes that a two-ounce bar of chocolate, one pint of beer, the most polite of afternoon teas—a buttered scone, a piece of cake and a cup of tea—have a caloric value of approximately 300 and that the daily requirement of the average person is only 2,500 calories, it needs very few 'snippets' to yield an excessive intake of food. Too, patients have little idea of food values and if they miss what they call a square meal, they frequently take a sandwich or cakes in place of the said meal, the caloric value of the latter often being much greater than that of a square meal. For example, one-half pint of beer and an ordinary meat sandwich have a greater caloric value than a meal composed of a reasonable helping of roast beef, greens, potatoes, a cup of coffee, a biscuit and a small piece of cheese." An occasional "drink" may affect the degree of weight loss. McCullagh, in discussing the rôle of alcohol in the induction of obesity, emphasizes that alcohol itself yields 7 calories per gram, although the question remains unsettled as to whether it is utilized as food. No one can lose weight who cannot control his appetite. The rôle of appetite in the control of body weight

TABLE 2.—Rigid Reduction Diet

Carbohydrate, 44; Protein, 64; Fat, 17; Calories, 585							
Food	Break-fast Grams	Dinner Grams	Supper Grams	Total Grams	Grams		
					Carbo-hydrate	Protein	Fat
Vegetables, 3 per cent		150	150	300	9	3	0
Vegetables, 6 per cent				100	6	1	0
Fruit, 5 per cent		100	100	200	10	2	0
Fruit, 10 per cent	100			100	10	1	0
Vegetables or fruit, 15 per cent				100	15	1	0
Vegetables or fruit, 20 per cent				100	20	2	0
Cereal (dry)				100	80	10	5
Bread	10			100	53	9	2
Cream, 20 per cent				100	5	3	20
Cream, 40 per cent				100	3	2	40
Milk, skimmed			200	200	5	3	1
Bacon				100	0	25	50
Eggs	1			Each 1	0	6	6
Meat (lean)		90	90	180	0	25	5
Butter				100	0	0	85
Mayonnaise with salad oil				100	0	0	85
FOOD VALUE OF THE DIET				Total grams	44.3	63.9	17.2
Calories from carbohydrate					(4 calories for each gram)		
Calories from protein					(4 calories for each gram)		
Calories from fat					(9 calories for each gram)		
Total calories					587.6		

has been described by MacLagan and Harrington. Evans and Strang, and Evans¹⁰⁻¹² have performed a splendid piece of work in emphasizing the importance of diets quite low in calories which contain adequate mineral and vitamin supplements in the effective reduction of any type of obesity.

Cole, Gray and Kallenbach, and Short all report satisfactory results when patients have been co-operative in following the diet. Short's patient lost 239 pounds while on the diet! Gray has published photographs of obese, adolescent patients cured without injections of any type, and these photographs I think should be memorized by all who are inclined to publish "before and after" photographs following some more dramatic type of treatment.

TREATMENTS OTHER THAN DIET

Treatments other than diet have been advocated from time to time. There are, of course, many claims of cures, later proven fraudulent, which have been brought to light and described in the *Journal of the American Medical Association*.¹ Thyroid extract has long been a popular drug for use in obesity.

The importance of insisting that the patient remain under continued observation while thyroid extract is being taken is emphasized by a report by Fancher of one patient who, without supervision, increased the dosage to 72 grains of thyroid extract a day. The use of dinitrophenol and desiccated thyroid has been most thoroughly reviewed by Simkins. The unfortunate results are well known to all. Raab and Werner and Weir have described the use of posterior pituitary extract. Lessem and Myerson report the use of benzedrine sulfate, and Hirsh prescribed propadrine hydrochlorid.

HOW SHALL DIET BE PLANNED?

If we are agreed that the use of a weight reduction diet is the best method for treating obesity, how shall we plan this diet? First of all, let us eliminate the fad diet from further discussion. These diets are often inadequate in proper food constituents and have nothing to recommend them. Great harm may follow the unwise adherence to an unscientific diet. Some obese patients will lose weight satisfactorily simply by eliminating from the

TABLE 3.—*Rigid Reduction Regimen—Simple Foods*

Breakfast		
Orange	100 grams	1 average orange
Bread	10 grams	½ thin slice
Egg		1 egg
Lunch		
Head lettuce	50 grams	¼ head
Tomatoes, stewed	100 grams	½ cup
Cold meat	90 grams	3 ounces
Peaches, canned	100 grams	½ cup
Dinner		
Carrot	12 grams	6 thin strips
Sauerkraut	125 grams	⅔ cup scant
Milk, skimmed	200 grams	1 glass
Pot roast of beef	90 grams	3 ounces
Apricots, canned	100 grams	½ cup

diet those foods which are rich in fat and carbohydrate. Such a qualitative restriction is not always effective and more rigid dietary restriction may be necessary. Diets containing about 1,000 calories are effective in reducing the weight of most obese patients, but we wish to discuss a diet containing only 585 calories per day. This diet should not be used indiscriminately and should not simply be handed to the patient. We never prescribe this diet unless the patient's physical condition has been exactly appraised, unless the patient promises complete co-operation, and unless the patient will eat his meals under supervision in the diet kitchen for at least one week. This is an accurately planned diet which

TABLE 4.—*Rigid Reduction Regimen, Fancy Foods*

Breakfast		
Grapefruit	100 grams	½ small
Bread	10 grams	½ thin slice
Egg		1 egg
Lunch		
Shrimp salad		
Shrimp	90 grams	3 ounces
Celery	50 grams	¼ cup
Dill pickle	10 grams	⅛ pickle
Lettuce	20 grams	2-3 leaves
(Mineral oil dressing)		
String beans	70 grams	⅓ cup
Pineapple	50 grams	¼ cup
Dinner		
Beef broth	200 grams	1 cup
Celery	25 grams	½ small heart
Mushrooms	100 grams	½ cup
Cucumbers	25 grams	5-6 thin slices
Milk, skimmed	200 grams	1 glass
Broiled steak	90 grams	3 ounces
Strawberries	50 grams	¼ cup

TABLE 5.—*Daily Vitamin and Mineral Supplements*

Substance	Dose	Vitamin or Mineral	Quantity of Vitamin or Mineral	Cost in Cents
Halibut oil	1 capsule	Vitamin A Vitamin D	10,000 170	.012
Thiamin chlorid	1 mg. tablet	Vitamin B ₁	333	.02
Meads Brewer's yeast	12 tablets	Vitamin B ₁ Vitamin B ₂	240 240	.043
Tribasic calcium phosphate	2 heaping table-spoon-fuls	Phosphorus and calcium	4.4 gm. 8.5 gm.	.046
Total cost				\$0.121

should be weighed on food scales. The diet prescription is described in Table 2.

We do not advise measuring this diet, but we have listed the approximate measures in the sample menus. The first menu is composed of simple foods, easily and cheaply obtained (Table 3); the second consists of more fancy foods (Table 4).

This diet is deficient in certain mineral and vitamin supplements and unless these are prescribed, patients will complain of weakness and hunger. At present the cheapest and best way of administering these supplements is described in Table 5.

If a patient is to follow such a strict diet, he must be able to see the results of his faithfulness. This can only be accomplished by furnishing him with a chart on which his anticipated weight loss is graphically illustrated. This chart can be drawn only if we know his estimated weight loss per week. This is determined by multiplying his daily caloric deficit by 0.002. This factor was determined by Dr. R. M. Wilder⁵² as follows: If D equals the calorie deficit per day, then $\frac{D}{9.3} =$ grams of fat loss per day (since 1 gram of fat produces 9.3 calories). Since fatty tissue contains approximately 86 per cent fat, the figure obtained above must be multiplied by $\frac{100}{86}$, which gives the grams of expected weight loss per day. Multiplying this figure by 7 converts this

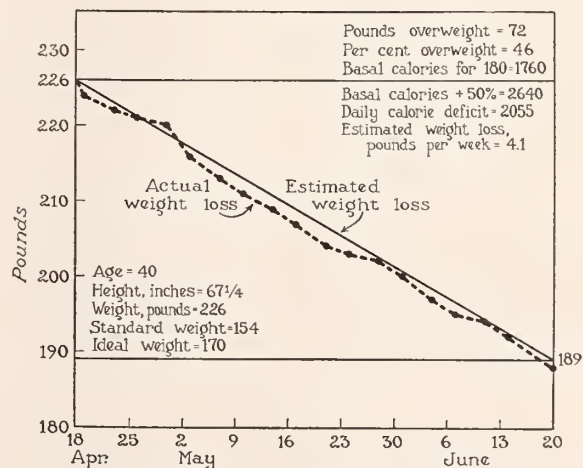


Chart 1.—Relation of predicted loss of weight (a) to the actual loss of weight (b).

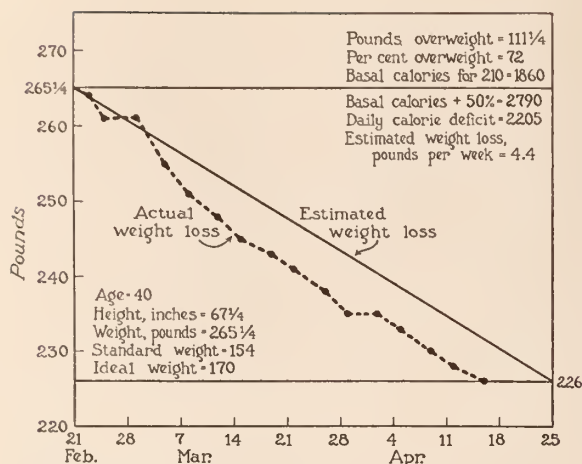


Chart 2.—Relation of predicted loss of weight (a) to the actual loss of weight (b).

figure to the expected weekly loss, and again multiplying by $\frac{2.2}{1000}$ converts the figures to pounds per week. In summary:

$$\frac{D}{9.3} \times \frac{100}{86} \times 7 \times \frac{2.2}{1000} = D \times 0.00193,$$

or approximately $D \times .002$. The following case illustrates the application of this method.

REPORT OF CASE

CASE 1.—A man, 40 years of age, was admitted to The Mayo Clinic on February 20, 1939, because of obesity and diabetes. He weighed 265¼ pounds (120.6 kilograms) and was 67¼ inches (168 centimeters) tall. The blood sugar reading was 138 milligrams per 100 cubic centimeters. The standard weight for a man of his age and height is 154 pounds (70 kilograms). We do not believe that standards should be followed too rigidly, and we arbitrarily selected 170 pounds (77.2 kilograms) as his ideal weight. He was, therefore, 111¼ pounds (50.6 kilograms) or 72 per cent overweight. All very obese patients lose more rapidly during the early weeks of their dietary restrictions than they do later, so that we plan the expected weight loss in several "steps." We planned the patient's weight reduction regimen so that he was first attempting to lose 55 pounds (25 kilograms), which would bring his weight to 210 pounds (95.4 kilograms). Using the Boothby-Sandiford tables, we find that the daily caloric requirements for a man forty years of age, who weighs 210 pounds (95.4 kilograms) and is at rest in bed are 1,860 calories. By adding 50 per cent to this figure for normal activity, we get 2,790 calories. By subtracting the 585 calories he is to be allowed, leaves a daily calorie deficit of 2,205 calories which, multiplied by .002, gives 4.4 pounds (2 kilograms), the estimated loss of weight per week. Fig. 1 shows that his loss of weight exceeded our expectations. The next table was planned in the same manner to reduce his weight to 189 pounds (85.9 kilograms). Again he was coöperative and again he lost the estimated amount of weight (Fig. 2).

By August the patient weighed 170 pounds (77.2 kilograms). He returned to the Clinic for reexamination and reported that while following this diet and taking the mineral and vitamin supplements he had been able to work every day at hard manual labor and had felt fine. His blood sugar reading and a sugar tolerance were within normal limits. A diet was prescribed containing 2,640 calories, which will enable him to maintain his weight at 170 pounds (77.2 kilograms).

CONCLUSIONS

All fat comes from food. Treatment for obesity is by the restriction of the intake of calories unless there is definite clinical evidence of an associated condition which requires special treatment. We have

never seen a patient who did not lose weight satisfactorily if this reduction regimen was rigidly followed. The addition of adequate mineral and vitamin supplements is an essential part of a rigid reduction diet, and very few patients complain of not feeling well when these supplements are taken.

The Mayo Clinic.

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(Continued in Back Advertising Section, page 40)

TRAUMATIC APPENDICITIS*

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AS used in this discussion, "traumatic appendicitis" may be defined as an inflammatory state of the vermiform appendix, resulting from extraneous mechanical injury. This definition thus excludes three other causative agents which might be construed as traumatic: (1) Bacterial trauma, following the usual infective invasion of the appendix; (2) Trauma produced by intraluminal foreign bodies themselves—for example, minute abrasions of the appendiceal mucosa caused by crystallized vegetable iron or by vegetable hairs (Shattock¹) or trauma caused by pins, seeds, worms, and so forth; (3) Trauma to the appendix when it is involved in an unrelated pathologic process, as when the appendix becomes strangulated in an inguinal hernia. This report is particularly concerned with appendicitis which follows severe forces applied to the abdominal wall. The subject is of importance, first, from a clinical standpoint, because of the possibility of including it among the clinical entities, and secondly, from a medico-legal standpoint, because of its occasional appearance in industrial compensation, accident

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insurance and liability litigation. In California, alone, the Industrial Accident Commission has reviewed fourteen cases between 1913 and 1937. In the forty-eight states the number must be well in the hundreds. The problem thus becomes similar to that of the relation of trauma to hernia. Inguinal hernia, even though known to result from developmental anlage, has become recognized as an industrial hazard, and now plays an important rôle in compensation cases.

TRAUMATIC APPENDICITIS, A CONTROVERSIAL SUBJECT

Traumatic appendicitis is a controversial subject. It is contended, on the one hand, that trauma is never responsible for appendicitis and, on the other, that trauma is of greater etiologic import than commonly is recognized. Deaver² stated that he never saw a case of acute appendicitis where injury was alleged to be the direct exciting cause, in which the appendix did not show evidence of previous disease. Foreign bodies, fecal concretions, strictures, and adhesions frequently are present without any suggestion of a lesion in the right iliac fossa. This view, however, is not inconsistent with the views of those who believe that appendicitis may be traumatic in origin.

Morehead³ stated that it is highly improbable that any violence could produce a lesion of such a deep-seated, movable, well-protected, tiny piece of intestine without damage to surrounding intestine nearer the source of violence and far more vulnerable. He saw no more relation between external trauma and appendicitis than between a blow on the neck and tonsillitis. Most textbooks agree that the appendix is immune to external violence or to the result of muscular strain on account of its deep-seated position and its mobility.

Murphy,⁴ in 1892, mentioned the possibility of traumatic appendicitis, but said that he had never seen a case. Von Neuman⁵ felt that trauma played a part in causing acute appendicitis in 6.6 per cent of all cases. Warbasse⁶ asked "if blows can rupture the normal intestine, why not the appendix?" Small⁷ believed trauma to be responsible for the increase in appendicitis over former years, and said that from 75 to 80 per cent of the cases of appendicitis in young adults resulted from trauma. Kelly,⁸ in his classical textbook, stated that not only does traumatic appendicitis exist, but that it is more common than is supposed, and is overlooked because no attempt is made to elicit history of injury. He reviewed fifty cases found in the literature. Osler⁹ wrote that persons whose work necessitates lifting heavy weights seem to be more prone to the disease. In his opinion, trauma plays a very definite rôle, and in a number of cases the symptoms have closely followed a fall or blow. The consensus of opinion in the literature is that there is a relation between trauma and certain cases of acute appendicitis. This is to be expected, since most reports include presentations of cases in support of the contention. Any controversial opinion arises from the fact that the appendix is commonly the site of infection, and that at operation it is not possible to discern a traumatic lesion which has

been overshadowed by an inflammatory one. As Ludington¹⁰ wrote, "No laboratory help has, in the past, been available to aid in the discrimination between traumatic and nontraumatic appendicitis, and as none seems likely to be forthcoming, the recognition of the traumatic case must, for the present at least, depend upon accurate clinical observation." White¹¹ said that when the appendix was removed and examination of the tissue made in the laboratory, it was impossible to say whether or not the condition of the appendix, which might be gangrenous and perforated, was caused by trauma.

Those favoring the existence of the entity argue that the mobility and deep-seated position of the appendix in the abdomen do not necessarily protect the organ, since the abdomen is not solid, but transmits force in directions other than the one in which it is applied. The gastro-intestinal content is a liquid-gaseous mass in which a force is transmitted equally in all directions. The deep location and mobility of the appendix, therefore, contribute neither to its vulnerability nor to its immunity.

Furbinger and Von Hansemann¹² filled the cecum with colored fluid and were able to express the cecal contents into the appendix by light pressure on the ascending colon, and by the introduction of air into the rectum. They deduced from this experiment that a blow upon the abdomen could produce the same result. Van Buren,¹³ conducting experiments on dogs, found that increased intra-intestinal pressure created hemorrhagic changes at the antimesenteric surface of the intestine. In mechanical ileus, such hemorrhagic infarcts are found. These may lead to perforation of the wall.

PATHOLOGIC CHANGES

The local pathologic changes which may occur in the production of appendicitis from trauma are of five types:

1. Force applied to the external abdominal wall may cause a rush of cecal contents into the lumen of the appendix and produce actual rupture. This probably is rare.

2. Mucomuscular tears may be produced, resulting in areas of fecal stasis and invasion of the appendiceal wall. Narrowing of the lumen from any cause, particularly by the pressure of a fecalith, enhances this possibility. Aschoff¹⁴ stated that, since the lymph follicles of the appendix push forward as far as the mucosa, it follows that if any injury occurs the mucosa could be ruptured down through the capsule of the node. After careful search he frequently was able to demonstrate the very delicate fissures filled with fecal bacteria which extended from the lumen into the substance of the lymph nodes. The presence of fissures does not necessarily prove that trauma occurred, but their presence does indicate that the lumen has been over-distended to the point of rupture of the mucosa, allowing organisms to enter into the substance of the wall. Pus sometimes is found dissecting the mucosa from the muscularis.

3. The violence may cause impaction of a fecalith in the lumen, producing intraluminary stasis. Since the appendix cannot empty, a "closed loop" type

of obstruction occurs. Likewise, a highly infected nidus is produced, which cannot drain.

4. A hemorrhagic infarct may be produced with subsequent perforation.

5. The force may impact a fecalith against the appendiceal wall, causing a point of pressure necrosis. It is of interest to note that Brunig¹⁵ found concretions in 65 per cent of the appendices that were removed following trauma, and in only 35 per cent of those not associated with injury. Kelly⁸ reported fecaliths in thirty of fifty cases.

Aschoff¹⁴ found that the most active primary focus of infection was just distal to the site of the coprolith, and that a focus of secondary importance was at the proximal end of concretion. The area in actual contact with the concretion was usually free of infectious material, probably because the crypts were "ironed out," and thus were less subject to infection. It may be appreciated that, whatever the mechanism of the production of the appendicitis, the inflamed edematous viscus, covered with fibrin and filled with pus or perhaps gangrenous, will tell little of the story of its initial pathologic changes. Free blood in the peritoneal cavity or histologic evidence of trauma are requisite findings. Morphologic proof cannot be adduced because it does not exist.

Rare cases of actual evidence of trauma to the appendix, however, have been reported. Lupton¹⁶ recorded an instance in which the abdominal musculature was said to have been "bruised," and hematomata of the ileocecal and ceco-appendiceal junctions were found.

It has been said that one would expect it to be true that traumatic appendicitis is more prevalent in persons with thin anterior abdominal walls, or defective or poorly developed abdominal musculature. This has not necessarily been the fact in the cases reviewed. As far as the musculature is concerned, the contributing causes of any intra-abdominal traumatic lesion are that the muscle be in a state of relaxation and the application of force be sudden and unexpected by the recipient. Kicks, blows, athletic injuries, vehicular accidents, strains in lifting heavy objects, falls against protruding objects, industrial accidents, etc., variously have been accused as direct etiologic factors.

The immediate clinical picture is that resulting from pain at the injured site, and "peritoneal shock." The development of epigastric or periumbilical pain and vomiting usually follows closely upon the injury. Later, after a period of comparative quiescence, symptoms and signs characteristic of appendicitis develop.

DIAGNOSIS

Shutkin and Wetzler set forth the following postulates which they felt must be met before a diagnosis of traumatic appendicitis could be made:

1. There must have been absolute freedom from abdominal complaints associated with pain, nausea, vomiting and tenderness, before the trauma.

2. Direct trauma must be severe and forcible, involving the abdominal wall in the right half especially.

3. Indirect trauma must be violent, acute, and unexpected.

4. Symptoms must appear immediately after the trauma.

5. Symptoms must be persistent and progressive, assuming the symptoms and signs of acute appendicitis.

6. The pathologic findings must indicate a suppurative destructive or necrotic process.

Recognition of the possibility is the salient point in treatment. Surgical care then follows the precepts for the treatment of acute appendicitis.

MEDICO-LEGAL ASPECTS

As mentioned previously, the medico-legal aspect of the subject is of considerable import. Usually the courts have held against the casual relationship of trauma and the development of acute appendicitis, and on the basis of expert medical testimony have ruled that the inflammatory process was coincidental. Undoubtedly insurance carriers have paid many claims for so-called "traumatic appendicitis" either for "policy reasons" or because the history of the case probably warranted the payment of such claim. In our own series, three of the seven cases immediately followed bona fide industrial injuries. In each of these instances the insurance carrier awarded the claim without causing the employer to file a claim before the Industrial Accident Commission.

The following are abstracts of the cases ruled on by the California Industrial Accident Commission from 1913 to 1937. Of the fourteen cases, only four were adjudged compensable.[†]

REPORTS OF CASES

CASE 1.—Sergeant P. R., 37 years of age, fell in the armory and struck the right lumbar region on a gun rack; thence he fell to the floor, striking the abdomen. The injury occurred on August 14, 1923. The patient was immediately and totally incapacitated on account of continued pain in the right lumbar region and right lower quadrant. Two weeks after injury the patient began to have increasingly severe abdominal cramps and vomiting, loss of appetite, weakness, etc. He first sought medical aid on September 8, 1923, when examination was made which revealed a sick man with marked ecchymosis over the right lower quadrant and right hip. At operation on September 20, 1923, a gangrenous perforated appendix was found with large retrocecal abscess containing several fecaliths. Appendectomy was done and the convalescence was uneventful. (Compensation was awarded.)

CASE 2.—J. R., 21 years of age, a laborer, was struck in the lower part of the abdomen by a heavy timber on December 17, 1937. Within a few hours the patient began to develop increasingly severe abdominal cramps, and he was unable to void. When seen in consultation on December 19, 1937, the patient was acutely ill with the typical symptoms and signs of a diffuse peritonitis with paralytic ileus. Operation was performed on December 19, 1937. There was evidence of trauma to the abdominal wall. A large gangrenous perforated appendix was found lying just over the brim of the pelvis. There was a diffuse plastic peritonitis. (Note: The insurance company considered the case compensable.)

CASE 3.—F. D., police officer, 28 years of age, was "kneaded" in the right lower abdomen during a scuffle on October 1, 1937. The patient immediately developed pain

[†] Case reports not recorded here, appear in the reprints.

Decisions of the Industrial Accident Commission of California in Cases Claiming Traumatic Appendicitis
YEARS 1913 TO 1937

Case No.	Reference	Method of Injury	Decision
1.	3:84, 1916	Struck abdomen on plank	Compensation awarded
2.	3:225, 1916	Sprain while lifting	Compensation awarded
3.	7:114, 1920	Sprain while lifting	Compensation denied
4.	8:112, 1921	Struck abdomen on plank	Compensation denied
5.	8:102, 1921	Struck abdomen against tongs	Compensation denied
6.	9:159, 1922	Swallowing dust of mouldy grain	Compensation denied
7.	10:248, 1923	Setting window frames (no definite injury)	Compensation denied
8.	11:7, 1924	Fell, struck right side	Compensation denied
9.	12:30, 1925	Strain while lifting (appendix strangulated in hernia)	Compensation allowed
10.	12:214, 1925	Struck in abdomen by tongs	Compensation denied
11.	13:80, 1926	Sprain while lifting	Compensation denied
12.	13:69, 1928	Struck abdomen against rail	Compensation denied
13.	19:145, 1933	Sprain while lifting	Compensation denied
14.	19:46, 1933	Struck abdomen against counter	Compensation allowed

at the site of injury. He continued to work, though with difficulty, for three days. Urination and defecation greatly aggravated his abdominal pains. He was nauseated, but did not vomit until October 3, 1937, when the symptoms became severe. Operation was performed. The cecum and terminal ileum, and the mesentery were markedly edematous and infiltrated, and were covered with plastic exudate. The appendix lay over the pelvic brim. It was gangrenous in its distal two-thirds and was perforated. (Compensation was awarded by the San Francisco Retirement System.)

CASE 4.—W. B., 11 years of age, a schoolboy, was struck in the abdomen by a volley ball. Abdominal discomfort occurred immediately, but gradually disappeared. Except for a poor appetite in the evening, the patient had no complaints. He slept well and went to school the next day. Late in the forenoon he developed a generalized "bellyache." He was given milk of magnesia and later vomited. The pain soon localized in the right lower quadrant. Operation was performed the day after the injury. The appendix was found lying over the pelvic brim. Early gangrene was present.

CASE 5.—H. P., a truck driver, 24 years of age, who had been injured forty-eight hours before when he pulled on a rope which broke suddenly, causing him to fall backward and strike the posterior aspect of the right flank on a piece of machinery. He suffered severe pain at the site of injury. An hour and a half later he began to have cramp-like pain about the umbilicus, which became more severe. That night he vomited and the pain shifted to the right lower quadrant, where it remained. At operation purulent fluid was found to be present in the peritoneal cavity. The appendix was gangrenous, perforated, and adherent to a thick, inflamed mesentery, and to the lateral posterior aspect of the cecum high in the right flank.

CASE 6.—C. C., a schoolgirl, age 13 years. On April 24, 1929, the patient was struck in the abdomen by a baseball. She immediately suffered pain in the right lower quadrant. She vomited a few hours after injury. She was taken to the hospital on the morning of April 26, 1929. The urine showed some granular casts and a few red blood cells. At operation, through a Battle incision, an acute perforated appendix was found lying high in the right iliac fossa in a retrocecal position. The perforation was caused by a pin which was forced through the appendix in its middle third. The head of the cecum and the right kidney were covered with fibrin. The appendix was nailed by means of the pin to the right kidney by the force of the blow which struck the right lower quadrant.

CASE 7.—B. J., a schoolgirl, 9 years of age, fell on the sidewalk, striking the right lower quadrant of the abdomen on the curb. Symptoms which began at that time increased in severity. At operation, the peritoneum showed subserous hemorrhage in the region of the incision. In the right lateral wall of the cecum there was a subserous

hemorrhagic area about the size of a dollar. There were areas of old hemorrhage in the meso-appendix near its base. When the appendix was split, areas of hemorrhage into the mucosa were seen corresponding to the hemorrhage in the meso-appendix. Microscopically, hemorrhages were discovered in the germinal portion of the lymphadenoid tissue.

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OSTEOMYELITIS OF THE BONES OF THE FACE IN A SEVERE DIABETIC: WITH RECOVERY AND PLASTIC RECONSTRUCTION*

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OSTEOMYELITIS of the bones of the face and skull has always presented a difficult problem to the rhinologist. Its association with sinus disease was first recognized by Luc and Tilley in 1899. Dan McKenzie of London in 1913 reported forty-eight cases. Of these, in forty-five the origin

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Fig. 1.—Lesion early in the disease showing large sloughing area with necrotic bone exposed.

of the infection was traced to the frontal sinus, while three were from the maxillary sinus. He remarked that the disease rarely originated in the ethmoid, as the infection usually caused a fatal meningitis before a true osteomyelitis could develop.

The infection may be divided into two types—spreading and localizing. The dividing line may be accounted for, at least partially, by variations in bone formation, and type and virulence of the process. The spreading type is usually fatal, but the localizing is not necessarily so. *Staphylococcus albus* or *aureus* is the organism usually recovered, although streptococci and pneumococci may be found.

The case we had the opportunity to follow, in addition to being a severe localizing type of osteomyelitis, was complicated by an advanced diabetes.

REPORT OF CASE

A 14-year-old girl, with a negative family and past history, began to lose weight in the summer of 1936. It was noticed that she developed increased thirst and polyuria, and looked poor; but she was not taken to a doctor.

In July of 1937, while on a vacation in the southland, she was taken acutely ill with follicular tonsillitis.

She was seen by Dr. W. P. Garrison of Long Beach on July 22, 1937, who reported to us the following:

"Her temperature was normal and her pulse 82. She was complaining of vague, indefinite pain in the left side of her face, but there was no swelling or edema. She was placed in bed and given symptomatic treatment.

"The following day her condition had changed markedly. Her temperature was still normal, but her pulse was 120, respiration 40, and she was stuporous. She was hospitalized and found to be in diabetic coma. Her blood sugar was 365 milligrams per cent, her urine contained 4 plus sugar and acetone. She was given alkalis, subcutaneous fluids, and insulin; and because there was some slight redness of the left side of the face, protosil was given intramuscularly in 5 cubic centimeter doses every three hours.

"On the following day, July 24, there was definite redness of the left side of the nose and face, which appeared like erysipelas, although there was no line of demarcation. Fluids and insulin were continued.

"The next day, July 25, the right eye and right side of the face were involved. Protosil was continued, and prontosil was given, 5 grains every three hours. Quartz light therapy was begun locally. The diabetes was controlled with multiple injections of insulin, up to 90 units a day. The temperature was swinging. On this régime for ten days, the infection of the right face and eye were controlled, and the infection of the left side became less acute.

"On August 3, she was given a transfusion of 500 cubic centimeters of whole blood.

"On August 5, under local anesthesia, the left antrum was drained, and necrotic tissue was removed from the left side of the nose at the inner canthus of the eye.

"On August 13, she was transferred to San Francisco."

When first seen by us she was a sick, pale, dehydrated, emaciated girl, complaining of pain in the left side of her face and left eye. The left face showed marked edema and cyanosis of the upper and lower lids. At the inner canthus of the eye, there was an area of necrotic tissue of about 2 by 4 centimeters in diameter. The left eyeball was protruding, and fixed and markedly injected. There was an early corneal ulcer and pus in the anterior chamber, and vision was lost. The right face was normal. The right nostril was essentially negative. The left nostril was filled with foul-smelling, dirty, yellow pus. Upon removal of



Fig. 2



Fig. 3



Fig. 4

Fig. 2.—Active infection has subsided. Globe has been removed. Lower lid pulled downward by scar tissue. Anterior end of middle turbinate may be seen through the fistula.

Fig. 3.—Pedicle attached at lower margin of fistula.

Fig. 4.—Fistula closed. Final reconstruction has not yet been completed.

this, the entire lower turbinate was gangrenous, and there was pus in the middle meatus. The throat was essentially negative, except that there was a large amount of pus in the nasopharynx. The ears were normal. There was no regional adenopathy and the thyroid was normal. The heart was not enlarged. It was regular, with occasional premature systoles, tones were good. The lungs were entirely clear. The abdomen was negative; liver and spleen not enlarged. Extremities were normal. Blood count showed 48 per cent hemoglobin, red count 2,740,000, white count 4,600 with 63 per cent polys. The urine showed 4 plus sugar, no acetone; blood sugar 444 milligrams per cent. Her weight was estimated at 88 pounds.

Clinical Course.—She was placed on a diet of protein 80, fat 115, carbohydrate 220, a total of 2,235 calories, and this was given in frequent small feedings throughout the day and night, as tolerated, but it was seen that the total amount of 220 grams of carbohydrate was taken in daily. She was given a daily dose of 40 units of protamin insulin, and urine specimens were followed four times a day, and small doses of old insulin, ranging from 5 to 25 units, were given three to four times a day in an attempt to keep the urine nearly sugar-free and continually acetone-free. She was given two transfusions the first two days of hospitalization. The sloughing area on the left side of the nose was irrigated with Dakin's solution several times daily, and the left nostril cleaned with gentle suction at frequent intervals throughout the day. No attempt was made to irrigate the left antrum or disturb the necrotic tissue.

Because of the apparent control of the spreading infection, sulfanilamide therapy was not continued, although hemolytic streptococci had been recovered from the pus.

X-rays, taken on entry, showed thickening of the frontals and ethmoid cells on the right and of the left antrum. There was osteomyelitis of the nasal bone, extending down at the inner margin of the left orbit.

For the next two weeks the local condition in the face remained about stationary, with continual sloughing of the base of the external wound, but no evidence of spreading infection, nor was the patient septic. Her temperature was low-grade, and the white counts were all within normal limits. She took her diet well, and the urine was kept continually acetone-free, and she slowly gained weight. By the end of a month the sloughing tissue was all removed from the external wound, and an area of bare bone was left exposed. The bone was necrotic but was still firmly fixed, so it was not disturbed. The eyelids were still markedly swollen and the eye itself remained as on entry. She was gradually allowed to be up and around and was dismissed on the eighth of September on the same diet and insulin, weighing 93 pounds.

She was then followed at the office and the necrotic bone began to sequestrate. Day by day, small bits were removed until eventually the left lacrimal bone, frontal process of the maxilla, paper plate of the ethmoid, part of the nasal septum, and entire lower turbinate had been taken away. This was all accomplished without causing any severe hemorrhage. This left a hole in the face through which the entire nasal cavity could be visualized. The maxillary and frontal sinuses could be readily entered and all other intranasal structures easily identified. She steadily gained weight to 105 pounds.

On the morning of October 12, the girl developed an attack of acute appendicitis. Under spinal anesthesia, Dr. H. B. Stephens removed an acutely inflamed appendix, with fecalith. The wound was tightly closed with black silk throughout, and on return to her room the patient was given intravenous glucose and insulin.

The day following surgery she was given her full carbohydrate intake in the form of glucose and water by mouth, and her insulin was continued. The second day postoperatively she was given a light diet containing all her 220 grams of carbohydrates. The urine again was followed carefully and small premeal doses of old insulin were given to keep her relatively sugar-free, and at no time did she show acetone. No attempt was made to keep her blood sugars entirely normal.

On October 20, while convalescing from the appendectomy, the dead left eye, which had collapsed through perforation of the corneal ulcer, was enucleated under evipal anesthesia by Dr. J. L. McCool.



Fig. 5.—X-ray showing osteomyelitis of the left nasal bone.

On October 23 she was discharged, weighing 108 pounds.

Plastic Reconstruction.—On November 9 she reentered the hospital for plastic reconstruction. Examination showed a large oval defect extending from the supra-orbital ridge down along the lateral nasal wall to the level of the infra-orbital foramen, outward to the medial portion of the malar bone.

The stump of the lower lid was pulled down so that the nasal margin was at almost a right angle to its normal position. A portion of the nasal margin of the upper lid was lost.

The problem of reconstruction was difficult in that the tissue loss consisted of supporting structure, lining and covering in an area where ridges and depressions meet, as well as where thin skin joins with thick skin. It was complicated by the infolding and curling of the conjunctiva, loss of lid substance in both the upper and lower lids, and the marked ectropion of the lower lid stump.

A forehead flap with lining graft was seriously considered for reconstruction but abandoned because of our dislike to create one deformity to cure another. A tubed pedicle was made beneath the left breast, lengthened and transferred via the back in order not to scar the chest above the nipple line. By lengthening the pedicle the skin was brought to the defect and anchored at opposite edges in four major steps, leaving enough and more for lining and covering flaps.

The orbit was restored and made ready for the reception of the prosthesis, without the necessity of lining grafts by careful dissection of incurled conjunctiva. The bony support was taken from the right iliac crest.

COMMENT

From the beginning this patient presented many interesting and unusual problems. Early in the disease a clinical picture of erysipelas was presented, but this soon showed its true nature when the subcutaneous tissues at the inner canthus of the left eye began to break down.

The use of sulfanilamide in the early stages probably controlled the infection and accounted for the fact that it remained localized. Later on the problem of management of the necrotic tissue was paramount. This was done by allowing the fragments of bone to sequestrate the same as is done in osteomyelitis in other parts of the body. As soon as a fragment of bone became freely movable it was carefully lifted from its position. We believe this to be the main point in the rhinological management of the disease, as no severe hemorrhage occurred at any time. (Many of the cases reported were brought to termination by severe uncontrollable bleeding because of too early removal of the sequestra.)

During the course of the acute infection in this patient, and for each of the many operative pro-

cedures, the diabetes was handled with a relatively high carbohydrate diet, a daily dose of protamin-insulin and small premeal doses of old insulin to keep the urine relatively sugar-free and at all times acetone-free. There was no attempt made to keep the blood sugars within so-called normal limits. It was seen that each day the equivalent of at least 200 grams of glucose was taken by the patient in four meals or in multiple small feedings during the day and night, even on the day of her operations, any deficit being made up with intravenous glucose. It is felt that in combating infection it is essential that the diabetic as well as the nondiabetic have always available sufficient glucose and insulin for the increased metabolism, and that acidosis must not occur. It is also felt that high blood sugars *per se* do not make for increased hazard of infection or for poor wound healing. But when these complications are seen in diabetics they are due rather to the lack of available combustible glucose, and this may occur if the patient is not given sufficient glucose and insulin, even though the urine is sugar-free and the blood sugars are normal or low.

In a nondiabetic who goes through an operation, intravenous glucose is frequently administered immediately following surgery, and sometimes kept up for two or three days because the surgeon feels that this is necessary to ward off acidosis and other complications. During this period of glucose administration the blood sugar of the nondiabetic varies from normal to 700 milligrams per cent, and the patient continually shows sugar in the urine and yet does well. It is exactly with this in mind that this patient was given practically all the glucose she could take and plenty of insulin, to make sure she was burning her glucose after each operative procedure, with no attempt being made to keep her blood sugars within normal limits or the urine sugar-free.

While at home the diabetes was controlled with a single daily dose of 50 to 60 units of protamin-insulin. On hospitalization for surgery the protamin-insulin was cut to approximately two-thirds this amount, to give a constant supply of insulin without the danger of severe reactions, changing her in a manner from a severe to a mild diabetic. She was then allowed to eat when and as desired, and the carbohydrate intake was carefully measured and the urine repeatedly tested for sugar, small doses of old insulin being given as indicated. Many times during her operative procedures she went to surgery with blood sugars over 200 milligrams per cent, and had blood sugars ranging 200 to 300 milligrams per cent throughout the day following surgery. At no time was it shown that these high blood sugars, in themselves, detracted in any way from the rapidity of her wound healing, nor did she ever vomit or have acidosis.

With the diabetic control favoring healing, reconstructive problems in this case evolved around the location rather than the type of the defect. The tissue loss necessitated restoration of both thin skin for the lid area and thick skin for the nose and cheek. The advantage of the tubed pedicle flap over the lined forehead flap was its adaptability to these conditions, even though texture, color, and

thickness were factors in favor of the latter. Bony support was given preference over cartilage because it does not bend, resists infection, and unites readily to the underlying bone. Isografts were not considered.

This case illustrates well again the necessity for close coöperation among specialists when many are caring for one patient. Too often the patient is lost between "specialists."

SUMMARY

1. A case of osteomyelitis of the bones of the face, due to hemolytic streptococcus, in a 14-year-old, severe diabetic, with recovery and plastic reconstruction, is reported.
2. Sulfanilamide may have been an important factor in the localizing of the infection.
3. The conservative management of the bony sequestra in this type of case is emphasized.
4. A relatively high carbohydrate diet with insulin was used in the diabetic management, without particular care to the control of blood sugars.
5. The problem of restoring a bad defect in a difficult area on the face, complicated by the loss of the eye, is briefly discussed.
6. After careful analysis a tubed pedicle was used, in preference to a lined forehead flap, for restoration.
7. Autogenous bone grafts were used for support.

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INFANTILE ECZEMA: ITS DERMATOLOGIC MANAGEMENT*

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THE term "infantile eczema" is a general one, covering a number of different conditions. In recent years there has been agreement, for the most part, as to what is included under this term. For the purpose of this discussion on therapy, the following division is made: eczematous fungus infections; seborrheic dermatitis; contact dermatitis; atopic dermatitis. Frequently two or more of the above are present at the same time.

Correct diagnosis naturally is most important. This does not mean, however, that the treatment then is routine for each type of eczema. Infants with the same kind of eczema will show marked differences in their response to the same medication. A slight modification in the preparation may be all that is necessary to achieve good results. Frequently, a change to some other medication is essential.

GENERAL CONSIDERATIONS

The first problem in treatment nearly always is the parents. They are, of course, upset and it is important to have their coöperation. They should be told several facts concerning the disease. It is

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not contagious except occasionally in the fungus type, and the health of the baby is not generally affected. There is no residual scarring and the skin will return to normal. In regard to prognosis, the infant has a 90 per cent chance of getting over the disease between the eighteenth month and the second year.

Instructions should be given the family concerning the baby's surroundings. The room should be scantily furnished, the closer to bareness the better. Exposure to sunlight and wind should be avoided. Tight-fitting and irritating clothing should be done away with. The clothing and bed clothes should be made of cotton so that the child does not come in contact with any wool. Feathers should be eliminated from the room and the floor should be mopped frequently so that no dust or lint accumulates.

Soap is another irritating substance which should not be used. Baths can be given and it is well to add starch or oatmeal to the water. The one exception for the use of soap is in treatment of the scalp. Here it is of advantage in removing the crusts.

Pruritus is the most distressing symptom, and is present in all forms of eczema. This should be controlled because a short bout of scratching will change a mild dermatitis into a severe one. If the baby is excoriating himself, splinting or tying of the arms is indicated. Small doses of a mild sedative may be needed. Ideally, babies with any marked involvement should be hospitalized, as they respond rapidly to this change in environment. Osborn has clearly demonstrated this point in a large group of patients which did not respond at home to any therapy, but were cured with simple remedies when hospitalized. In any severe case, hospitalization should be urged.

ECZEMATOUS FUNGUS INFECTION

This form of infantile eczema is not frequently seen. It usually involves the inguinal and gluteal folds. These infections are usually characterized by sharp margination. They are not vesicular, but weeping can be present. The color generally is a deep red. There is usually peripheral exfoliation. The central portion shows maceration of the superficial layers of the epidermis. Fissuring is common along the lines of the folds. The offending organism is easily identified in the scrapings.

These cases usually respond well to treatment. Local therapy consists of a powder or a simple lotion such as calamine lotion, N. F. or a starch lotion. A paste, such as Lassar's in which there is incorporated a 1 or 2 per cent ammoniated mercury, is useful in the drier forms. Gentian violet, 2 per cent in aqueous solution, painted on the areas once or twice a day, is often efficacious in the monial types of infection.

Prescription I. Mild antiseptic dusting powder

Powdered boric acid, zinc oxid, purified talc., each in sufficient quantity to make 30 grams.

Mix and dispense in sifter-top can.

Label: Use freely as required.

Prescription II. Antipruritic starch lotion

Phenol	0.25 to 1.0 per cent
Liq. Carbonis detergens (Wright's)	5.0 to 10.0 per cent
Zinc oxid	48.0 grams
Starch	48.0 grams
Glycerin	24.0 grams
Liquor aquae calcis.....	Sufficient to make 240 grams

Particular attention should be paid to the diapers. They should be boiled, and the last rinse should be a mild antiseptic solution, such as boric acid or a very weak solution of bichlorid of mercury. Rubber pants should not be used.

Fungous infections due to the trichophyton group, when occurring on trunk or extremities, usually are well treated with about half or quarter strength Whitfield's ointment. Another excellent remedy for this type of infection is an ointment containing 2 per cent sulphur and 2 per cent salicylic acid in petrolatum.

SEBORRHEIC DERMATITIS

This type occurs on the scalp, cheeks and, less frequently, the axillae and inguinal folds. It is made up of inflammatory patches with a considerable amount of scale, which has a greasy, yellowish appearance. It is most marked on the scalp. This is seen most frequently in babies who are overweight, and reduction in weight is of considerable help in treatment. The first step is to remove the scales. This is done by gently rubbing with gauze soaked in olive oil. This is the one form of eczema in which soap can be used in place of the oil to remove the crusts. After the scale has been removed, the area is dried and an ointment applied. Mild sulphur ointments, 1 to 3 per cent, are the most efficacious and have nearly a specific effect. Preparations having the same percentage of ammoniated mercury are also extremely useful.

CONTACT DERMATITIS

While this is the most common form of eczema in the adult, it does not present a great problem in infants. It should always be considered, however, and definitely ruled out before treatment is started. The eruption may be vesicular and is usually inflammatory and pruritic. There are ordinarily only one or two localized areas involved, and these most frequently occur on exposed surfaces. The first thing after the diagnosis is made is, of course, to remove the cause, as, for example, a dermatitis from a sweater. Wool and feathers, as has been shown by Osborn, are the most frequent cause of this type of eczema. Other substances, which should be excluded from the environment, are silk, kapok, pyrethrum, soap, and mercury in its various forms. Osborn feels that this latter is frequently the cause of hypersensitivity in infants. This develops early from the use of baby oils having mercury as the antiseptic. If the external irritation is found and removed, treatment is simple, as most of these eruptions will involute rapidly. In the weeping and vesicular stage, compresses of a saturated boric acid solution or Burow's solution

(liquor aluminum acetate, diluted 1-8; 1-15) are of value. A soothing lotion, such as calamine, is frequently all that is necessary. A paste, such as Lassar's, with a quarter to a half per cent of phenol for its antipruritic effect, is of value.

ATOPIC DERMATITIS

This is the classical form of infantile eczema. The face and flexor surfaces of the extremities are the sites of predilection. It is characterized by weeping, crusting, lichenification, and extreme pruritus. It is in this form that the diet is of particular importance, as will be brought out by others in this symposium. External irritants, such as feathers and wool, also play an important rôle, as in the contact type. For the weeping and crusting stage, the method of choice is compressing or applying massive wet dressings. Treating large areas is best done in the hospital. A few layers of moist gauze or cotton is not a wet dressing, because the exudate will stick to it and irritate the area and when it dries it does more harm than good. The dressings should be made from unstarched gauze or soft linen, saturated with the solution to be used and wrung out so that it is not dripping. This is placed on the affected areas, and should be at least two inches thick. The dressing is then covered with some sort of impermeable material, such as cellophane, to keep the dressings from drying. A dry bandage or towel is then put on to hold the dressing in place. To put such a dressing on the face requires considerable nursing skill. When improperly applied, a wet dressing is worse than none. Dressings should be changed every three to four hours. A wet dressing can be made with saturated boric acid solution, Burow's solution 1-8, 1-20; potassium permanganate 1-5000 is an excellent solution if any secondary infection is present. After weeping and crusting have subsided, which should be in a few days, ointments are in order.

By far the most useful single remedy is crude coal-tar. One should make sure that eastern crude coal-tar is being used, and details should be given to the pharmacist if he does not know how to make the preparation. It should be smooth and dry. If it is not properly prepared, it crumbles and tends to aggravate the skin. Its proper preparation is with equal parts of crude coal-tar and zinc oxid mixed together. Then starch and petrolatum are mixed. These two mixtures are then worked in together to form a smooth black paste. This is applied gently to the affected areas, if there is any weeping and erythema present. If the areas are lichenified, the ointment should be rubbed in.

Prescription III. Crude coal-tar ointment

Crude coal-tar.....	4.0 grams
Zinc oxid	4.0 grams
Mix and add	
Starch	30.0 grams
Petrolatum	30.0 grams

Mix and label: Apply to affected areas two or three times a day.

Crude coal-tar can be used in full strength, the liquid being painted on the affected areas every other day. After the affected areas begin to show slight exfoliation, the tar should be stopped, and a simple paste of equal parts of boric acid ointment and Lassar's paste should be used. If the tar is used too long a dermatitis may develop. This is frequently of a follicular type. Another preparation which has been useful in my hands is a 10 per cent ichthyol incorporated in Lassar's paste. This is less irritating than crude coal tar. Naftalan, a mild tar used in 5 to 10 per cent strength, has the same indications as ichthyol.

COMMENT

No attempt has been made to include all the various remedies that are of value in the different types of infantile eczema. One treating these cases should become completely familiar with the medications he is using, so that the changing of only one or two per cent of any one ingredient in the course of the disease will mean involution, and not evolution, of the process. There are a few general statements that may be made:

1. Change of environment (hospitalization) is beneficial.
2. Removal of wool and feathers as common cause of contact reactions should always be done.
3. Dermatitis from local medication should be watched for. Mercury is the worst offender.
4. Weeping areas should be treated with wet dressings or compresses before lotions and ointments are used.
5. On inflamed areas, pastes are better than greasy ointments.
6. Recurrences are frequent, some unexplainable and others due to carelessness in following detailed directions.
7. Always remember that great majority of infants clear around the age of two years.

411 Thirtieth Street.

EPILEPSY*

A GENERAL SURVEY OF THE CONVULSIVE STATE

By JAMES A. CUTTING, M. D.

Agnew

CONVULSIONS occur in a truly bewildering variety of conditions. Paresis, brain tumor, diabetes, alcoholism, brain trauma, hysteria, uremia, and tetanus are but a few of fifty or more organic, toxic and functional disorders associated with convulsive manifestations.

Because of the mystery surrounding its etiology, the title of idiopathic epilepsy was given to a group of so-called spontaneous seizures; but just as fever and pain are symptoms of an underlying pathology, so should the epilepsies, or convulsive states, be considered.

The finding of neolithic skulls, with trephine openings to allow of the escape of the devils caus-

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ing epilepsy, antedating the written records of man, speaks for the antiquity of the disease. In the United States today, with an estimated 600,000 persons suffering from convulsive disorders and with over 40,000 of these confined in state psychiatric institutions,¹ it still remains one of the great social and economic problems.

In the state hospitals of California last year there were 22,608 patients.² Of these, 665 were epileptics whose yearly cost has been estimated at \$151,620. During the year, one hundred new cases of epilepsy were admitted. Of these patients, none had received a collegiate education, only eighteen had gone through high school, and 48 per cent were entirely dependent. There were thirty-six deaths among the epileptics and of these twenty had been in the hospital for an average of twelve and one-half years. These figures give but a small idea of the seriousness of the situation.

Those suffering from convulsive disorders and yet not hospitalized still remain a handicapped group. As automobile operators they are a serious problem, and their choice of occupation is necessarily limited, inasmuch as their sudden seizures cause a hazard both to themselves and to others. In large colonies these people do quite well together. At Agnew a practice is made to have male epileptics work on the lawns in groups of twos and threes. If one falls during a seizure, he has a soft carpet on which to fall, and the other patients in the group care for him until he is again ready to carry on. In this way they may even take trips into the country.

DIAGNOSIS

The diagnosis of epilepsy in a state hospital case is usually not difficult. In its incipency, however, this may be fraught with much uncertainty. Fainting spells, with convulsive movements, may resemble epilepsy very closely. Indeed sleep, faints, syncope, convulsions, petit and grand mal epilepsy, all have a strikingly similar underlying mechanism.

To elaborate further: sleep, as pointed out by Rosett,³ does not occur all at once but step by step through the sensory, associative, and motor fields. Thus, as one lies down to sleep the body is no longer in need of vestibular help to maintain equilibrium, visual stimuli cease, and auditory sensations are cut to a minimum. This allows the associative and thalamic fields to fill the mind with vivid and inaccurate memory images. As these fade, the motor area, at first active, next recedes, and the individual becomes, as it were, decerebrated. It is often possible at this stage to obtain a positive Babinski, and it is here that the familiar jerking movements are so apt to occur. Next the muscles become flaccid, no deep reflexes are obtained, the last neuron pathway through the stem and cord is closed, and the individual passes into a profound stage of sleep. Awakening proceeds in the reverse order.

STAGES OF AN EPILEPTIC SEIZURE

The various stages of an epileptic seizure can, according to Rosett,³ be closely correlated with those of sleep. Thus, a typical seizure is frequently ushered in by an aura with an accompanying narrowing of the sensory fields. One patient, E. S.,

described this aura to me as follows: "I feel funny, things seem to be floating before me, it's like looking through a fog. I seem to be reaching out for something, and then falling into space, dark space."

Following this suppression of the sensory field, associative and thalamic release next ensues, bringing with it vivid imagery and hallucinations, with an increased feeling tone. Patient G. V. explained the sensory aura to me as follows: "I can tell when it is coming; I feel ill in the pit of my stomach and a hot feeling comes in my left ear." Then follow hallucinations of hearing with a feeling of fear, as she puts it: "I get afraid and have a feeling that men are coming up from behind to grab me, and I can hear them say: 'Come on, we are going to get you.'" The patient next becomes unconscious as the wave passes on, and with the loss of the cerebrocerebellar pathway there ensues a state of tense muscular rigidity known as the tonic phase of the convulsion. Following this comes the jerking clonic convulsive movements of the whole body. At about the time these generalized convulsions are over, it is frequently possible to obtain a positive Babinski, indicating that the corticospinal pathway through the pyramidal tract has been extinguished. Following the convulsion, the muscles lose their tonicity and become flaccid, showing again that the last and most fundamental pathway of stem and cord has been blocked out. Recovery, as in sleep, proceeds in the reverse order: First, the muscles regain their tone, movements take place, dreams are common, and the patient, though at first confused, regains his usual conscious state once more.

This wave of disability may recede at any stage of the seizure and cause the syndrome to be only partially completed.³ Thus one may have only the preliminary aura without further trouble, or it may go on to a momentary loss of consciousness without proceeding to the convulsive stage. Thus patient A. Z. came to my office one day and, in a somewhat euphoric mood, began telling me how long it had been since he had had a convulsion. "Doctor," he said, "it's been at least six months since I've had a spell, yes, sir, at least six months." Suddenly, with a far-away look in his eyes, he turned, walked to the corner of the room, picked up a feather duster and, holding it before him as he would a candle, made a tour of the room as if looking for some lost object. Then, replacing the duster in the corner he came back, and as he focused his gaze on me once more, continued: "Yes, doctor, it's been all of six months since I've had a spell." He had, of course, just experienced an epileptic equivalent of which he himself had no appreciation.

OTHER PHASES

As stated above, faints are often accompanied by convulsive movements, and are hard to distinguish from light attacks of epilepsy. Fainting is often preceded by the feeling that everything in the environment is floating away. Daylight seems to be a long way off and, finally, complete blackness ensues. Gowers cites several cases in which fainting attacks eventually developed into true epilepsy.⁴

It is interesting and significant to note that dizziness, syncope, and fainting can be caused by pres-

sure on the carotid sinus. It is also suggestive that, by exerting more and more pressure on the sinus, convulsions can be produced. The symptoms caused by this pressure, according to Smith,⁵ are aura with spots before the eyes, epigastric distress, light-headedness, unconsciousness, and mild convulsions—the typical syndrome of epilepsy. According to Weiss,⁶ in some cases carotid pressure causes a slowing of the heart and a lowering of the blood pressure. In other cases it neither lowers the blood pressure nor slows the heart, but acts directly on some brain center, probably producing a sudden change in the cerebral vessels, consisting of a contraction followed by dilatation, thus accounting for the syndrome. The occurrence of dizzy spells, fainting spells, and generalized convulsions were found in 16 per cent of a series of one hundred consecutive cases of senile and arteriosclerotic psychosis, as reported by Tompkins.⁷ Of these, 6 per cent were of the epileptoid character, 7 per cent were convulsive, and 3 per cent showed a profound and lasting change in consciousness. It would be hard to believe that these dizzy spells, faints, and convulsions were not all an integral part of the convulsive state.

Convulsions can likewise be produced by drugs, such as insulin and metrazol, which are used extensively in the shock therapy of schizophrenia. These convulsions resemble epileptic seizures and can, of course, precipitate attacks in those suffering from epilepsy.

COMMENT

Great progress has been achieved in brain surgery through the use of delicate electrodes in producing convulsions by spotting the aural center which sets off the convulsive explosions, but much argument has arisen as to what course these convulsion-producing waves pursue. Penfield⁸ likens the condition to a cyclone, which sweeps through the brain, causing wild, uncoordinated muscular contractions.

Recently, however, Erickson⁹ has demonstrated quite convincingly that, in monkeys, convulsion-producing waves follow along the motor convolution from one contiguous area to the next, probably by means of the short intracortical association fibers. When this wave—*e. g.*, one passing up the convolution from the arm to the leg area—is interrupted by a transverse ligature, it does not jump the gap and continue up to the foot center, but crosses by way of association fibers through the corpus callosum to the corresponding arm area of the opposite hemisphere. Here it continues a course up this convolution to the leg center, where it recrosses above the ligature and into the leg area of the original hemisphere.

This theory of the progression of waves would seem to apply to the sensory as well as the motor area if the description of an aura, as given by my patient B. B., is correct. She stated that she first noticed a numbness arising in the toes of the left foot. This numbness proceeded up the leg into the thigh, along a narrow band from the thigh to the left shoulder, thence down the arm and out into the fingertips of the left hand. (This patient was left-handed.) It will be noted that this description

follows in sequence the contiguous sensory areas as mapped out by cerebral experimentation. Occasionally, this patient said, when the sensation reached the left hand there followed almost simultaneously a feeling of numbness in the right hand. Efforts had been made by teachers to make this left-handed individual right-handed. This suggests that a deepened pathway through the corpus callosum might account for the occasional crossing of the aural wave from the left to the right hand.

The fact that so many seizures occur at night would also suggest that, through sleep and the abeyance of the sensory field, the first step in the neuron arc toward the convulsive explosion has already been taken. The powder seems to lie somewhere along the associative, thalamic, or motor pathway. It might even reside in some localized irritative lesion of the sensory area, where it remains ready to be set off by the constant pulling of this trigger.

Why these waves should start, no one as yet knows. Starr¹⁰ cites the case of a young girl who was suddenly awakened at night by her brother, who had covered himself with a white sheet. She was much alarmed and one hour later had a major attack. Following this she became a confirmed epileptic. Fright was given as the cause in this case, yet the fact remains that ordinarily no one would develop epilepsy from such a fright. However, it might have been the precipitating factor in a subject potentially an epileptic. Such seems to have been the case in a diminutive-sized schoolgirl, M. R., whom I saw playing a trombone in an orchestra. At the end of a long number in which she had played a trombone solo, leading up to the grand finale, she gave a last supreme blast. As she did so, she fell from her chair with a cry and experienced a generalized convulsion. The hyperventilation in a potential epileptic had done its work. To date, seven years later, she has had no further trouble.

Recent work in electro-encephalography tends to show that this convulsive potentiality is present in certain individuals, and indications are that this type of work will be of great help in the understanding and prevention of these convulsive disorders.

The most noteworthy advance in recent medical therapy is the discovery of dilantin sodium which, unlike most drugs, does not produce drowsiness, but at the same time is most effective in reducing the number of seizures.¹¹

SUMMARY

In this survey of the convulsive states, the following points have been emphasized:

1. The economic and social importance of caring for 600,000 epileptics.
2. The similarity in the fundamental mechanism of the convulsive state with sleep, faints and syncope, as evidenced by carotid pressure, cortical stimulation, and clinical manifestations.
3. The momentous aid given by modern research to the understanding of these convulsive disorders.

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THE INTERPRETATION OF LABORATORY EXAMINATIONS IN THE DIAGNOSIS OF INFECTIOUS DISEASES*

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PART II†

ANOTHER type of infection that may be extremely acute and accompanied by vegetative endocarditis, which may give no murmurs, is that resulting from hemolytic streptococcal infection. The following case is an example.

A man, 44 years of age, develops fever, abdominal pain, and diarrhea, followed by jaundice, hematuria, nitrogen retention, and Streptococcus hemolyticus bacteremia. Death in ten days with acute bacterial endocarditis and focal embolic nephritis.

CASE 4.—This patient was in excellent health until four days before admission to the hospital. At that time he developed nausea and vomiting and shortly thereafter had abdominal cramps. The following day he had frequent loose bowel movements. The vomiting, abdominal cramps and diarrhea increased in severity until the time of admission. He also complained of chilliness and sweats, which appeared off and on for two days before admission.

Examination showed a well-developed individual who appeared acutely ill. He was mentally clear and cooperative. His temperature was 102 degrees Fahrenheit, pulse rate 110, blood pressure 120/60. Examination of the head, nose and throat proved negative. The heart and lungs were clear throughout. There were no cardiac murmurs. The abdomen showed slight tenderness over the upper half, but no masses were felt and the spleen was not palpable. The

extremities showed an amputation stump of the left leg below the knee. Rectal examination was negative.

Urine examination showed no albumin, one or two white blood cells, and rare erythrocytes. The red blood cell count was 4,500,000, hemoglobin 81 per cent, white blood cell count 14,300. Nonprotein nitrogen was 50 milligrams per 100 cubic centimeters.

The clinical course in the hospital was one of progressive failure, the temperature varying between normal and 100 degrees Fahrenheit. On the fourth day after admission to the hospital, the seventh day of his illness, he became deeply jaundiced and the icteric index was recorded as 100 units. At the same time there was a progressive increase in his nitrogen retention. The urine contained no albumin, only a few white blood cells and red blood cells. On the fifth day the jaundice was increasing and the patient developed gross hematuria. The liver edge was felt two fingerbreadths below the costal margin; it was smooth but not especially tender. No murmurs appeared over the heart. Blood cultures, taken on the seventh, eighth and ninth days, showed hemolytic streptococci.

The clinical course, then, was that of a man who had been perfectly well until nine days before his death, when he was seized with abdominal pain, nausea and vomiting, and diarrhea. This was followed by fever, the development of jaundice, and the appearance of hematuria, with hemolytic streptococci in the circulating blood. Necropsy showed acute vegetative endocarditis of the aortic, mitral, and pulmonic valves and acute bronchopneumonia. In brief, this was an instance of hemolytic streptococcal sepsis with jaundice and vegetative endocarditis, focal embolic nephritis, and renal insufficiency. The nonprotein nitrogen of the blood increased from 50 to 188 milligrams per 100 cubic centimeters between the first and the seventh day of his illness. Here again is an instance of infection with bacteremia in which it was not possible to discover the primary focus or portal of entry. The course was extremely acute and produced lesions on the heart valves, which had not progressed to the stage where the leaflets were destroyed but were large enough to give origin to numerous emboli which went to the kidneys and produced a focal glomerular nephritis. The diagnosis of streptococcal infection during life would not have been made without blood culture.

‘ ‘ ‘

The above cases illustrate how bacteremia aids one in making an etiologic diagnosis of an otherwise obscure infection. Blood cultures may also provide one with information when there is a mixed infection, such as is illustrated by the following case.

A common problem in diagnosis is the explanation of fever which recurs following a pneumococcal lobar pneumonia. While the possibilities must include the search for focal infections, i. e., empyema, endocarditis, or meningitis, very often there is an infection due to another organism, such as a hemolytic streptococcus, and the diagnosis is made by culturing the blood and examining the pleural fluid or sputum. Such cases, of which the following is an example, have been reported by Parsons and Myers,¹⁰ Finland,¹¹ and Curphey and Solomon.¹²

A young man with pneumococcus Type I pneumonia and bacteremia fails to respond to large amounts of specific serum. Sputum contains large

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† Part I appeared in CALIFORNIA AND WESTERN MEDICINE in the issue of September, 1940, on page 111.

numbers of hemolytic streptococci, as well as pneumococci. Blood culture later becomes positive for hemolytic streptococcus.

CASE 5.—This man was admitted to the hospital with the classical signs of lobar pneumonia due to Type I pneumococci with bacteremia. In spite of the administration of large amounts of antipneumococcus horse serum, the temperature did not return to normal, as is customary in most cases of Type I pneumococcus infection treated with serum. Re-examination of his sputum showed that the patient had a mixed infection, since the pneumococci were accompanied by large numbers of hemolytic streptococci. On the eleventh day of his illness there were signs of a mediastinal pericarditis with a loud friction rub, which was synchronous with the heart beat and was exaggerated by respiration. On the thirteenth day of his illness hoarseness developed and he was unable to speak above a whisper. On the following day he had pain under the gladiolus and difficulty in swallowing. He died on the seventeenth day of his illness. The results of culture of the blood, beginning on the fourteenth day, showed that he had numerous colonies of hemolytic streptococci in the circulating blood. Necropsy showed a resolving pneumonia of the right lung with many abscesses, diffuse mediastinitis, and empyema (hemolytic streptococcus) on the right side in the anterior mediastinal pleural space.

This case, information about which was obtained only by careful examination of the sputum and repeated blood cultures, emphasizes the importance of recognizing mixed infections as a cause of pneumonia.

THE SIGNIFICANCE OF NEGATIVE BLOOD CULTURES

When there are symptoms and signs of an infection without bacteremia, the following interpretations can be placed on this finding: (1) that one is dealing with an infection not due to a pyogenic organism; (2) that the infection is localized, and the defense mechanism of the body is adequate to prevent an invasion of the blood; or (3) that the infection is caused by an anaerobic organism.

For example, it is infrequent to find bacteremia in mastoiditis, tonsillitis, pyelonephritis, or pyelophlebitis, and when any of these diseases are associated with bacteremia it usually means an extension of the process to the neighboring veins or a rupture of the local defense mechanism. In about 20 per cent of cases of bacterial endocarditis, the blood cultures are persistently negative, and there is evidence from a study of these cases that the organisms fail to grow, not because of faulty technique but because of the presence of a high titre of immune bodies in the circulating blood.

In any case in which the symptoms of a pyogenic infection are present without bacteremia, it is highly suggestive of a localized infection with a defense mechanism that is adequate to localize the infection, but that may be inadequate for complete sterilization of the focus.

AGGLUTINATION TESTS

Specific serological reactions in the blood are of the greatest aid in the diagnosis of infections which do not produce bacteremia. They are a definite sign of an immune response to the infecting organism. Repeated examinations are of greater significance than an isolated observation, since an increasing titre is the rule in an active infection, whereas a low, stationary titre must be assessed with greater

judgment. In general, it can be said that a positive agglutination reaction in the blood indicates previous experience with that group of organisms and, in many cases, it is a sign of an active infection. Agglutination reactions are of the highest value in the diagnosis of the enteric infections (Eberthella, Salmonella, and dysentery infections), in undulant fever, tularemia, rickettsial disease, and in the diagnosis of glandular fever.

Concerning agglutination tests in general, one may say that they must be interpreted in the light of clinical features of the disease. Positive reactions mean either previous experience with the organism or an active infection. If the titre of agglutinins increases during the period of observation, then the diagnosis of an active infection is almost certain. If it is low and remains stationary, then its significance, in so far as diagnosis is concerned, is less certain.

In regard to Widal examinations, the following general rules are helpful:

1. Agglutinins for typhoid bacilli in a titre above 1:40 are rarely, if ever, found in the serum of individuals who have not been vaccinated or who have not had typhoid fever in the past.

2. Many laboratories now report the results of H (flagellar), O (somatic) and Vi (somatic-virulent) antibody titres in their Widal tests. From a single agglutination test one may be reasonably safe in making a diagnosis of typhoid fever, if there is a high titre (1:250 or higher) of H agglutinins in an uninoculated person, or a titre of 1:1000 in a person who has not been inoculated recently, or an O titre above 1:250 in the uninoculated or not very recently inoculated.

During the course of typhoid fever an individual may develop no H agglutinins while developing O agglutinins. For this reason it is always advisable to carry out the tests with both antigens.

When an individual with the clinical picture and course of enteric fever fails to develop antibodies, it may be due to one of the following reasons: (1) he may have some other disease; (2) the test was carried out too early in the course of the disease; or, (3) the proper antigen was not used—an insufficient number of strains were included in the tests to detect agglutinins against organisms which are capable of producing enteric fever.

Melitensis Agglutination Tests

In the interpretation of these tests, the following points are significant:

1. A negative agglutination test does not exclude B. abortus or melitensis infection.

2. A positive agglutination test, regardless of the titre, means previous experience with this organism. When the titre is above 1:80, it generally means an active infection.

3. It is always well to use high, as well as low dilutions of serum in order to eliminate the phenomena of prozone reactions; that is, positive agglutinations in high dilutions and no agglutination in low titres.

Tularemia Agglutination Tests

Positive reaction in dilutions of 1:80 or over are significant. The following points, however, must be considered:

1. There may be cross-reactions between *B. melitensis* and *B. tularensis*. When this occurs, the titre for *B. tularensis* usually increases in active infections and the melitensis agglutinins remain stationary.

2. Specific agglutinins are usually absent during the first week of the disease and become positive during the second week; but they may be delayed in their appearance as long as the third week.

3. The maximum titre is often reached in the third week and remains high for four to seven weeks and then declines. It rarely disappears entirely and may be positive for as long as twenty-five years.

Dysentery Agglutination Tests

This test is valuable in the diagnosis of dysentery when organisms can not be isolated from the stools. When formalized cultures are used, an agglutinin titre of the serum of 1:25 and 1:40 is suggestive of the presence of an active infection. A number of different strains should be used in the tests.

Proteus OX19 and OX2

Positive agglutination reactions for *Proteus* OX19, OX2, and OXK are important in the diagnosis of the various rickettsial diseases, especially in endemic typhus and the group causing Rocky Mountain spotted fever. Titres of 1:80 or 1:160 are significant.

* * *

The following cases illustrate the value of agglutination tests in diagnosis.

It was stated previously that one occasionally encounters a patient who has all the symptoms and signs of enteric fever with negative Widal examination and blood culture. This may be explained, in part, by failure to use the proper antigens in studying the blood for specific agglutinins, as shown by an example of such a case.

A man with the clinical picture and features of enteric fever has negative blood cultures and agglutination reactions against typhoid and paratyphoid B organisms. Positive agglutination reaction for B. aertrycke.

CASE 6.—A young, mechanical engineer, 27 years old, was admitted to the hospital in a confused and mentally cloudy state. He was irrational, disoriented and extremely ill. He was unable to give a history of himself but from members of his family it was learned that two weeks before admission there was a sudden departure from health, symptoms of an infection, and slight diarrhea. Within four days he had high fever, diarrhea and vomiting, which continued up until the time of admission to the hospital. It was stated that he had received typhoid inoculation on two occasions in the past; the first time eight years before admission and the second two years. He had been exposed to unsanitary conditions due to work in an area where floods had recently been prevalent.

Examination showed a young man who was acutely ill, disoriented and irrational. Tongue was dry and coated, the lips were parched, the skin was hot and dry, and there

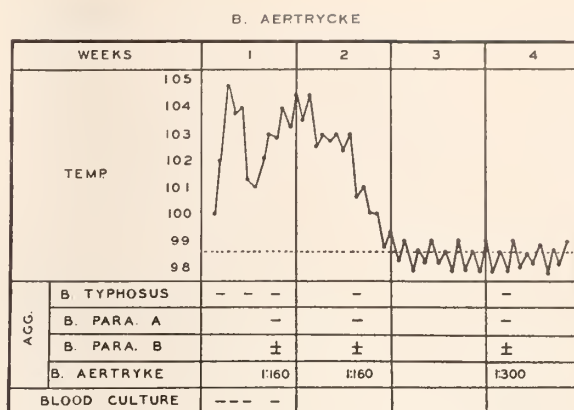


Fig. 3.—(Case 6) Chart showing temperature curve and results of agglutination reactions and blood cultures in a patient with enteric fever due to *B. aertrycke* infection.

was slight icterus of the sclerae. Scattered over the skin of the trunk and, to a lesser extent, on the arms and legs were numerous pink macular to maculo-papular areas ranging in size from 2 to 4 millimeters in diameter, which blanched on pressure. The head, neck, heart and lungs revealed nothing abnormal. The abdomen was moderately distended, the spleen was easily palpable 3 centimeters below the left costal margin in the midclavicular line, and the liver was not felt. Rectal examination was negative.

The urine examination showed a trace of albumin, a small amount of bile pigment and acetone. The sediment had an occasional cast, with an increase in the number of white blood cells. The urine was concentrated. The white blood cell count was 7,050, with an essentially normal differential count. Stools were soft, semi-solid, and contained a small amount of occult blood. Blood culture on admission was negative, as were agglutination reactions against typhoid, paratyphoid A and B, *B. melitensis*, and Weil-Felix reaction. The cultures on the urine and stools, which were made three days before admission to the hospital, were likewise negative for the enteric group of organisms.

Repeated stool cultures showed, on one occasion, gram-negative organism having the sugar fermentation of bacilli falling into the salmonella group. When *B. aertrycke* were included in the antigen for the Widal test, it was found that they were agglutinated in a titre of 1:160. This was repeated on several occasions.

The course of the patient's temperature is seen in the accompanying chart (Fig. 3). The clinical course was characteristic of enteric fever, but the absence of bacteremia and the negative Widal examination with the common organisms usually causing enteric fever was somewhat confusing. When the *aertrycke* were included in the antigen used for Widal examination, they were then found to be positive. The course was uneventful and the patient made a complete recovery.

Unless the *B. aertrycke* organisms had been included in the antigens used for carrying out the Widal tests, the etiology of this particular case of enteric fever would never have been determined.

Harvard Medical School.

(To be concluded)

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CLINICAL NOTES AND CASE REPORTS

INTRADERMAL TUBERCULIN: PARENTAL REASONS FOR REFUSING

By ORREN LLOYD-JONES, M. D.
Los Angeles

THE mass testing for tuberculosis of adolescents and young adults as carried on in Los Angeles high schools must begin by obtaining parental consent for the test. Contact of the school with the parent is for the most part indirect; by word of mouth through the student, and by letter and questionnaire addressed to the parent. But whatever the approach to the parent, we come far from winning universal consent for the test; 60 to 70 per cent of the school enrollment is a good average.

REASONS ADVANCED FOR REFUSALS

With the thought of ascertaining the basis of parental refusal of the test, we included in the case of a few schools, as an item to the questionnaire, the sentence, "If you refuse the tuberculin test, kindly state why?" In about one-third of the returned questionnaires, this request for information was ignored. The refusals available for study numbered 1,432.

Statistical study of this material was made by Mr. Herbert Sauer of the Los Angeles Tuberculosis and Health Association, one of the coöperating agencies in this case-finding project; and some of the figures are shown below, based on 1,432 replies:

Reason	Per Cent
Not necessary.....	28.7
Private physician.....	27.0
Previous tuberculosis examination.....	13.6
Belief, religious.....	14.5
Belief, secular and not specified.....	12.0
Other reasons.....	4.2

The most common reason for refusal, 28.7 per cent, was the belief that the test was not necessary: "Has always been healthy," "A sturdy, strong child," "No chance to get tuberculosis," etc., being typical replies. We must accept this situation as a challenge to the adequacy of health education among the populace. Over 90 per cent of the enrollment of these schools is made up of white children, and most of the schools concerned are located in the "best" areas of the city. Yet about 29 per cent of these parents have not grasped the fundamental facts that, first, exposure to tuberculosis is virtually inevitable, and, second, early tuberculosis may give no symptoms whatever and produce no signs.

Almost as large a group, 27 per cent, gave as a reason for their refusal, that all health problems were entrusted to their physicians: "Leave such matters to our doctor," "My doctor attends to these things," "Our physician has apparently not felt it necessary," etc. To the extent that the physician in private practice believes that the routine case-finding program is advisable, the en-

trusting of such confidence on the part of the parents would seem to be a challenge to him, and this 27 per cent of refusals, as a measure of his neglected opportunities. But this overstates the case. Busy or indifferent parents, unwilling to bother with thinking the situation through, have undoubtedly given this reply as an "escape" or as a rationalization of their *laissez faire* attitude toward health matters, which does in truth account for their negative action. Based on the few cases which we followed up, we may state that it was rare indeed for the parents even to have telephoned their physicians concerning the matter of the proposed skin tests.

About 15 per cent of the refusals were due to religious beliefs. This group, at the present time at least, may be considered as a fixed segment of resistance to public health progress not open, in a school program, to approach.

Almost an equal number, 12 per cent, expressed, as the basis of refusal, contrary beliefs of a more secular character, such as: "Against belief," "Do not approve," "Do not believe in test," "Opposed to injections and serums," etc. Many of this group, like the first mentioned, only await enlightenment to become more coöperative, and are ready to listen if they can be reached.

Of the previously tested 13.6 per cent, the great majority had already been given, but some had been tested by private physicians and clinics in various parts of the country.

COMMENT

No phase of the general tuberculosis control program in our country has been more rapidly expanded during the past decade than mass testing among the schools. No other device can so easily bring to light the minimal cases among young persons and, where a proper epidemiologic follow-up is carried on, lead so directly to heretofore unsuspected sources of infection.

It appears from the data presented above that the chief barrier to the universal success of this program is the lack of understanding on the part of the public concerning the nature of tuberculosis disease. Yet many agencies are deeply and actively engaged in health education aimed to create this understanding. The schools themselves already figure large in this program, and every "Life Science" course presents innumerable opportunities to direct the students thinking toward health matters in some measure. As evidence that such opportunity is not being entirely wasted, we may cite the results of a small survey made at one school (the Los Angeles High) where 63 per cent of students in Life Science classes took the test compared with 52 per cent of the entire student body. However, among the 37 per cent of those Life Science students who did not take the test, the reasons given by the students for not doing so show that they themselves entertained essentially the same false beliefs as did the parents who refused permission.

Undoubtedly, physicians have in the past hesitated to offer the intradermal skin test with subse-

quent chest x-ray of the positive reactors to healthy young persons, fearing that such action might be interpreted as exploitation. We shall do well to keep in mind, however, the widespread activities in public health education now being carried on among the people, and to realize that our clientele is rapidly being made ready to accept this service when it is offered by their family doctor.

We have no one to thank but ourselves if we allow the tuberculosis test to become almost the accepted field of public health agencies, as we have already done in the case of smallpox and diphtheria immunization. In the meantime, those among us whose clientele is unable to pay for this service can vastly increase the effectiveness of these important preventive measures by explaining the basis and justification of the test as carried on by public health agencies.

1930 Wilshire Boulevard.

TUBERCULOSIS IS WHERE YOU FIND IT

By JOHN L. GOMPERTZ, M. D.
Oakland

EVER since Laennec discovered auscultation, physicians have been listening for adventitious sounds in the chest. Hearing none and eliciting no other abnormal findings, they have concluded that no pathological condition of the chest existed. This teaching has persisted through years so that unless a patient presented himself with most of the classical symptoms and signs of tuberculosis, too often his chest was dismissed as negative.

Not so many years ago the disease tuberculosis ranked first among all causes of death in this country. In 1900 the mortality from this condition was 202 per 100,000. Since that time the picture has changed considerably and today this disease has descended to seventh place among causes of death; by 1938 the mortality rate from it having dropped from 202 down to 48.6 per 100,000.

Many factors have contributed to this improvement, such as better treatment, public education, improved diagnostic measures; and, hence, earlier diagnosis, case-finding methods, and finally the realization on the part of the physician that tuberculosis may be active in a patient without the classical picture of "consumption."

Indeed, this is probably one of the most important truths that has dawned upon our medical consciousness: tuberculosis may be active and progressing without any signs or symptoms of it being apparent to the patient or to the physician making an ordinary examination.

To illustrate this, the following cases are offered.

REPORT OF CASES

CASE 1.—I. S. Age, 21. This patient worked as a beauty operator near a university campus and all of her clients were college girls. She felt fine, never was overtired; had no cough nor any other symptoms of illness.

One night in July 1937, however, she coughed a little bit and noticed some blood streaks on the sputum. Her mother became alarmed and sent her to the family physician, who had a chest x-ray taken. This revealed a cavity in the right upper lobe about one-half inch in diameter, with an area of infiltration around it. (Fig. 1.)



Fig. 1.—Showing small cavity in right upper lobe.

Her tuberculin test was found positive; she was hospitalized and her pneumothorax started. Today the cavity is closed, and she is receiving her pneumothorax treatments regularly and is back at her old job. She had felt perfectly well until blood appeared when she coughed.

The next step after making the diagnosis on this patient was to check her contacts; those people about her who might be infected. There were four members of her family, and they were all tuberculin-tested and fluoroscoped. Each was found to be negative until her younger sister was examined.

The sister was a very athletic girl of nineteen. She was a star basketball player and girls' yell leader in her high school. She had never known a day of illness and was the picture of good health and energy. She was examined and no physical signs of disease could be found. However, when she was fluoroscoped, an area of infiltration was found in her right upper lobe just below the clavicle. Her tuberculin test was positive and she was hospitalized and her treatment started.

Today she is still feeling perfectly well, because she was examined as a contact and an early diagnosis of tuberculosis was made. She, too, is back at work and is leading a very normal life.

COMMENT

Now these two cases present nothing unusual so far as pathology, clinical course or treatment are concerned. Their diagnosis was easy and their prognosis is good. They are presented to emphasize two points:

First, that a person may feel perfectly well and look fine, yet have active pulmonary tuberculosis.

Second, that all contacts to a case of active tuberculosis should have an adequate examination; at least a tuberculin test and then, if that is positive, some type of x-ray examination.

426 Seventeenth Street.

LEIOMYOMA OF VAGINAL WALL

By THOMAS M. TORGERSON, M. D.

AND

WILLIAM E. ROGERS, M. D.
Santa Rosa

SOLITARY leiomyomas of the vagina are uncommon tumors, yet may be of importance because of malignant transformation, local mechanical factors and the possibility of sepsis. While this instance does not illustrate any one of these points, it is of value from the statistical standpoint.

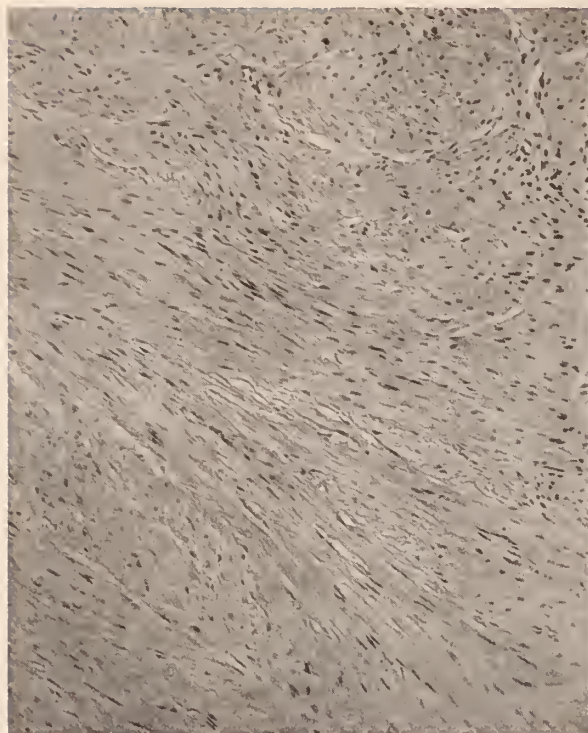


Fig. 1



Fig. 2

Fig. 1.—Photomicrograph (120x) of section of tumor, showing cells which resemble smooth muscle cells. Note bundle of cells.

Fig. 2.—Same (500x), to show nuclear structure.

REPORT OF CASE

CASE 1.—A white, married, nonparous female, aged 42, was first seen on October 10, 1939, at which time she complained of menorrhagia, metrorrhagia, pain in the left hip and knee, and frequency of urination. Eight years before she had been treated in a sanatorium for one year for pulmonary tuberculosis. Roentgen and physical examination of the chest on October 25, 1939, showed no sign of active tuberculosis. Seven years ago she had a left oöphorectomy. A pelvic examination in October, 1939, revealed no changes in the uterus or adnexae. The vagina had well-marked rugae, but no tumor was demonstrated in the wall.

Laboratory Report.—Hemoglobin (Sahli), 78 per cent, 12.8 grams; red cell count, 3.90 per cmm.; white cell count, 6,000 per cmm.; differential count, normal; urinalysis, essentially negative.

Progress.—The patient was put on theelin, 5,000 units i.m., twice weekly, in the hope that the menorrhagia and metrorrhagia were due to ovarian dysfunction. Since she showed no response to these, a uterine curettage was done on November 13, 1939. The scrapings proved to be hyperplastic endometrium, without evidence of malignancy. At the time of operation, the vagina showed no abnormalities. After curettage her menstrual cycle returned to normal. Several pelvic examinations were made during the subsequent months, each of which revealed no abnormalities of the vagina. On March 29, 1940, a routine pelvic examination was done. At this time a small, pea-sized mass was found lying just beneath the vaginal mucosa in the left lateral wall at the inferior level of the cervix. The mass was nontender, moveable, and not attached to the underlying tissues. There was neither redness nor induration of the overlying mucosa.

On April 4, 1940, the patient was taken to surgery and, under novocain infiltration, a small hard tumor, including the overlying mucosa, was removed. It measured 1.5 by 1 cubic millimeter in the fresh state. It was white, solid, and noncystic.

Pathologic examination by Dr. David G. Mason of St. Luke's Hospital, San Francisco, revealed the following changes:

Gross Pathology.—An oval-shaped tumor, measuring .8 by .6 by .5 centimeters in diameter, is present. It is white,

solid, and on section is found to possess smooth, greyish-white surfaces. One block of this is used for a section. A piece of flat vaginal mucosa, measuring 2 by 1.5 centimeters, is also received.

Microscopic.—Microsections (photo 1 and 2) of this small nodule show it to be formed by well-differentiated, elongated cells resembling smooth muscle cells. These cells are arranged in broad bundles, seen both in the cross and longitudinal plane. There was little to no fibrous tissue present, as shown by the Van Gieson stain. There was no evidence of malignancy.

Pathologic Diagnosis.—Solitary leiomyoma of the vaginal wall.

On examination on July 10, 1940, three months after removal of the tumor, the wound was found to be well healed.

SUMMARY

An instance of uncomplicated leiomyoma of the vagina occurring in a 42-year-old woman is reported.

507 College Avenue.

STREPTOTHRIX OF THE LUNG*

REPORT OF CASE

By JULIUS ZELMAN, M. D.

Murphys

FUNGUS infections of the lung present diagnostic problems for the clinician as well as for the bacteriologist. Emphasis is placed on careful study of the patient, and the use of a method available for obtaining a satisfactory specimen for laboratory study. In this case report, a specimen obtained at bronchoscopy was invaluable in the diagnosis.

* From the Department of Public Health (San Francisco) Tuberculosis Service. Sidney J. Shipman, M. D., chief; Alfred Goldman, M. D., bronchoscopist.

Until 1932 only sixty-five cases had been published under the heading of "Streptothrix." Since then two cases have been made known by Kerlan.¹

In the San Francisco Hospital, in the period of July 1, 1919 to June 30, 1936 (fiscal years), 19 of 167,547 discharges were for fungous infection of actinomycosis or streptothrix group. Of these nineteen, only four had pulmonary involvement, and the diagnosis was made in three at autopsy. One was diagnosed as a bronchogenic carcinoma; one as a tuberculosis with an effusion; another an empyema of unknown origin, diagnosis made from pus recovered at operation; and the last was secondary to a skin lesion. In two of the above cases, the initial complaint was pleuritic pain, followed two to six months later by hemoptysis and a productive cough. An empyema was a complication in two cases and a retroperitoneal abscess in one. In all cases, repeated cultures of the sputum and pus were necessary before organisms were recovered.

REPORT OF CASE

B. C., white, male, aged 43, single, baker. Entered hospital on February 24, 1938.

History.—On January 1, 1938, patient noticed a swelling on his left hip, which became progressively larger with time. Associated with the above was loss of weight and weakness. He consulted a physician and entered a private hospital. Here the swelling was incised and allowed to drain. The patient remained in the above hospital three weeks, during which time the abscess continued to drain and a cough, productive of a purulent sputum, developed. He then entered the San Francisco Hospital, complaining of a draining left hip abscess, loss of fifteen pounds, deep, dull pain in right chest and shoulder on respiration, and a productive cough.

His past history was essentially negative, except that the patient lived in Bakersfield nine years prior to his San Francisco residence of two years.

His examination here showed a temperature swing of 99.0 to 100.0 degrees Fahrenheit, pulse of 85, and respiration 22. His skin and mucous membranes were pale and moist, mouth hygiene poor, and dyspnea was present on the least amount of exertion in bed. Chest signs were limited to the right side, with wasting and lag on respiration. Vocal fremitus was increased, dull to percussion, particularly to the base posteriorly. Expiratory note was prolonged and an area of egophony was present anteriorly to the fourth interspace. Subcrepitant râles were present over this area. Laboratory report showed: red blood cells, 3,800,000; hemoglobin, 80 per cent; white blood count, 7,800; polymorphonuclear, 70 per cent; lymphocytes, 25 per cent; monocytes, 4 per cent; eosinophils, 1 per cent; Wassermann and Kahn was negative. Sputum was negative for acid-fast organisms on direct smear. The x-ray report of February 26, 1938, read: "There is a retraction of the right rib cage, with displacement of the heart to the right and partial atelectasis of the lower lobe. The entire right lung shows an irregular infiltration. There is thickened pleura, and possibly a small amount of fluid in the pleural space. There are no changes about the left hip."

During the following month a biopsy of the sinus was taken, and a thoracentesis of the chest was performed. The thoracentesis resulted in a dry tap, and the report of the biopsy revealed nothing but chronic granulation tissue. On April 1, 1938, a bronchoscopy was performed, at which time smears and cultures were taken for laboratory diagnosis. On April 6, 1938, a coccidioides skin test was negative. By April 9, the patient developed a swelling in the midline of the neck over the thyroid cartilage. This hard swelling became fluctuant in four days and, although two attempts were made to aspirate fluid from the mass, no free fluid was obtainable. Three days later the mass broke

during the night and drained. Cultures from this drainage were negative, except that some yeast-like colonies were found.

On May 1, 1938, the patient developed a tender swelling in the right loin, unaccompanied by fever, chills or urinary complaints. On examination there was a brawny swelling in the right loin, occupying the whole space between the lower ribs and ilium, pointing anteriorly beneath the anterior abdominal wall, but not attached to it. The mass was tender, warm, and did not move with respiration, and its location suggested a perirenal relationship. The diagnosis at this time was against the usual pyogenic perinephritic abscess, because of the absence of fever, and was thought to be most likely a psoas abscess.

The x-ray examination of May 20, 1938, revealed a clearing of the process in the right lung, with the diaphragm markedly elevated. In view of these findings, a right psoas abscess, pointing into the flank with definite suppuration of an actinomycotic group, seemed likely. On June 3, 1938, the patient was operated on the flank.

He was placed with the right side up, and an incision paralleling the crest of the right ilium and down the wall muscles was made, and a large abscess cavity containing about 100 cubic centimeters of foul pus was opened. This cavity extended downward and upward as far as one could probe with the finger, and appeared to involve only the region of the stomach muscles. The peritoneum was not opened. Specimen of the pus was sent to the laboratory for diagnosis.

Drainage continued until August 20. All wounds, except the original sinus and the right lung, had cleared markedly by x-ray, cough had disappeared and the patient had gained fifteen pounds in weight.

On August 24, final laboratory report was obtained and showed that the organ isolated from the specimen obtained at bronchoscopy grew anaerobically in media to which blood had been inoculated. It was pleomorphic in character, nonacid-fast, and stained both Gram-negative and Gram-positive. Typical branching was seen. The organism obtained from culture was inoculated into a guinea pig, and the animal, at autopsy, failed to reveal any lesions.

COMMENT

This case presented a problem in diagnosis. After entry into the San Francisco Hospital the patient developed lesions in his neck and flank. Whether the lesions were metastatic or contiguous was not determined. However, it was interesting to us that as soon as the lesions were opened and drained, healing took place without sinus formation, suggesting an anaerobic character of the causative organism. The organism was atypical in form, but the culture characteristics were those of the actinomycosis group and more specifically of an anaerobic streptothrix.

We also point to the invaluable aid of the bronchoscope in obtaining uncontaminated specimens for culture.

Iodids were of no avail in therapy, but marked improvement seems to take place after thymol therapy. The patient was eventually discharged afebrile, sputum-free, and all sinuses closed.

Bret Harte Sanitarium.

Treatment of older patients suffering from tuberculosis is one of our major problems in the eradication of the disease. A third of the patients in sanatoria are over forty years of age. Temporary forms of collapse treatment in older patients are less apt to be successful than the permanent form provided by thoracoplasty. One hundred sixty-two patients between the ages of forty and sixty-five treated by thoracoplasty showed improvement of 84 per cent, with 35 per cent returning to work.—Richard H. Overhold, M. D., *Amer. Rev. of Tuberc.*, February, 1940.

¹ Kerlan, Milton: A Report of Two Cases of Streptothrix of the Lungs, *Med. Jour. & Record*, vol. 135 (Feb. 17), 1932.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HARRY H. WILSON.....President
HENRY S. ROGERS.....President-Elect
LOWELL S. GOIN.....Speaker
PHILIP K. GILMAN.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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4. *Committee on Public Health Education.*
5. *Committee on Postgraduate Activities.*
6. *C. M. A. Department of Public Relations.*
7. *California Physicians' Service.*
8. *County Societies.*
9. *In Memoriam.*
10. *Woman's Auxiliary to the California Medical Association.*
11. *Nevada State Medical Association.*

OFFICIAL BUSINESS

CALIFORNIA MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

Digest of the Minutes of the One Hundred and Seventieth (170th) Meeting of the Executive Committee of the California Medical Association

Held in the offices of the Association, Room 2004, 450 Sutter, San Francisco, California, Sunday, September 15, 1940, at 10 a. m.

1. Call to Order.

The meeting was called to order by Chairman Charles A. Dukes. The following members were present: Henry S. Rogers, Lowell S. Goin, Philip K. Gilman, Donald Cass, Charles A. Dukes, and George H. Kress.

2. Financial.

(a) Council Chairman Gilman reported that he approved the suggestion of the Association Treasurer that two new savings accounts be authorized:

(1) "Herzstein Bequest Fund of California Medical Association" account in the Wells Fargo Bank and Union Trust Company: savings account No. 70290 (deposit, \$802.26); and

(2) "California Medical Association Permanent Endowment Fund"; savings account No. 11362 (deposit, \$242).

Doctor Gilman stated that these accounts had been opened in order to maintain the integrity of the respective funds, since the monies accruing to each had been given to carry out specific purposes. The action authorized by Council Chairman Gilman was approved by the Executive Committee.

(b) Report was made that the United States Treasury Department, through the local Commissioner of Internal

Revenue, in a letter dated August 31, 1940, had denied the claims of the California Medical Association for refunds on moneys paid for excise taxes and penalties. The Legal Counsel was instructed to make a report thereon at the October 6 meeting of the Council.

(c) Resignation of Miss Lucile Bradford as bookkeeper was received and, on motion duly made and seconded, was accepted, with appreciation for her long period of past service.

3. Medical Preparedness.

Dr. Philip K. Gilman, Chairman of the California Committee on Medical Preparedness, and Dr. Charles A. Dukes, a member of the California State Council of Defense, outlined plans thus far made concerning this important work.

4. Survey of Association Offices.

Dr. Philip K. Gilman, Chairman of the Special Subcommittee, authorized by the Council at its meeting on June 29, reported that this subcommittee had unanimously agreed to recommend that Mr. John Hunton, a resident of San Francisco, whose qualifications had been noted in a letter sent out to members of the Council, be employed as business manager of the Association. Doctor Gilman stated that Mr. Hunton would be able to take up his work on October 1, 1940.

5. Annual Session.

(a) A report was made by Doctor Kress, Chairman of the Committee on Scientific Work concerning the plans for more extensive scientific exhibits to be displayed at the next annual session in Del Monte.

Upon motion duly made and seconded, it was voted that the Committee on Scientific Work be authorized to offer prizes and certificates of award; the grand total of prize moneys not to exceed \$200.

(b) Upon motion duly made and seconded, Dr. Mast Wolfson of Monterey was elected chairman of the Local Committee on Arrangements.

6. Letter from the Los Angeles County Medical Association.

A letter from the Los Angeles County Medical Association, dated August 12, 1940, calling attention to a recent announcement by the Associated Hospital Service of Southern California in regard to indemnification for x-ray and laboratory services, was considered.

On motion by Lowell S. Goin, duly seconded, it was voted to recommend to the California Medical Association Council that the Council withdraw approval of the Associated Hospital Service of Southern California if steps are not taken by that organization to comply with the conditions laid down at the time original approval was given by the California Medical Association.

7. Woman's Auxiliary: Use of Bali Room at Del Monte.

Request of representatives of the Woman's Auxiliary to the California Medical Association to use the Bali Room of the Hotel Del Monte on Monday evening, May 5, 1941, in order to provide ample facilities for certain entertainment features was considered. Because the House of Delegates of the California Medical Association consists of 167 members, with many alternates and members of the California

(Continued on Page 182)

† For complete roster of officers, see advertising pages 2, 4, and 6.

(COPY)

*Rocky Mountain*OCTOBER
1940Colorado
Utah
Wyoming*Medical Journal***Editorial*

(COPY)

Mr. Roosevelt Replies

IF you read this page of our September issue, you remember that it reproduced, photographically, a letter from the Republican Presidential candidate and explained the circumstances leading up to preparation of that letter. The letter, dated August 7, 1940, at Colorado Springs, contained only three short sentences in addition to address, salutation, and signature, as follows:

"My Dear Doctor—You have asked my views on socialized medicine. I am against it. You can quote me any place on this. Cordially yours, (Signed) Wendell L. Willkie."

You will also remember this *Journal's* offer of identical space in this, our October issue, to President Roosevelt, should he care to reply as the Democratic candidate. This offer was carried also in a letter to Mr. Roosevelt, dated August 22, 1940, enclosing a proof of the editorial page then on our presses for the September issue.

We have received the following letter from the White House, with which was enclosed a mimeographed copy of an address delivered by Mr. Roosevelt on the occasion of the dedication of the Jersey City Medical Center. Both are reproduced in full:

THE WHITE HOUSE
Washington

September 6, 1940.

Dear Mr. Sethman:

This acknowledges your letter of August twenty-second with enclosure. The President's views on the subject about which you inquire were expressed in a speech delivered at the Jersey City Medical Center, Jersey City, New Jersey, on October 2, 1936, and, for your information, I have much pleasure in enclosing a copy of that speech. The views expressed by the President on that occasion have in no wise been changed or modified since the delivery of the speech in question and still constitute a complete statement of his principles.

(Signed) STEPHEN EARLY,
Secretary to the President.

Enclosure.

"It is a privilege to take part in the dedication of this Medical Center—the third largest medical institutional group in the United States.

"I am happy, too, that the Federal Government, through its Public Works expenditures, has been able to be of assistance to the municipal government of Jersey City and to

Hudson County in making this Center possible. As a matter of fact, the expenditures through the Public Works Administration are increasing the capacity of American Hospitals by nearly 50,000 beds. During the depression the difficulty of obtaining funds through municipal or private sources would have meant a serious shortage in caring for patients and in giving them adequate facilities had it not been for Federal assistance through loans and grants.

"But there is another reason for increasing the bed capacity of the hospitals of the country. The medical and nursing professions are right in telling us that we must do more to help the small-income families in times of sickness.

"Let me, with great sincerity, give the praise which is due to the doctors of the Nation for all that they have done during the depression, often at great sacrifice, in maintaining the standards of care for the sick and in devoting themselves without reservation to the high ideals of their profession.

"The medical profession can rest assured that the Federal Administration contemplates no action detrimental to their interests. The action taken in the field of health as shown by the provisions of the splendid Social Security Act recently enacted is clear.

"There are four provisions in the Social Security Act which deal with health; and these provisions received the support of outstanding doctors during the hearings before Congress. The American Medical Association, the American Public Health Association, and the State and Territorial Health Officers' Conference came out in full support of the public health provisions. The American Child Health Association and the Child Welfare League endorsed the maternal and child health provisions.

"This in itself assures that the health plans will be carried out in a manner compatible with our traditional social and political institutions. Let me make that point very clear. All states and territories are now coöperating with the Public Health Service. All states except one are coöperating in maternal and child health service; all states but ten in service to crippled children, and all states but nine in child welfare.

"Public support is behind this program. But let me stress, in addition, that the Act contains every precaution for insuring the continued support and coöperation of the medical profession.

"In the actual administration of the Social Security Act we count on the coöperation in the future, as hitherto, of the whole of the medical profession throughout the country. The overwhelming majority of the doctors of the nation want medicine kept out of politics. On occasions in the past attempts have been made to put medicine into politics. Such attempts have always failed and always will fail.

"Government, state and national, will call upon the doctors of the nation for their advice in the days to come.

"It is many long years ago that Mayor Hague and I discovered a common interest in the cause of the crippled child. This great Medical Center is, I know, close to his heart. I congratulate him on the fulfillment of a splendid dream. I congratulate Jersey City and Hudson County on modern facilities surpassed by no other community in America."

* CALIFORNIA AND WESTERN MEDICINE, in its September issue, on page 133, reproduced a page from the August issue of the *Rocky Mountain Medical Journal*, giving candidate Willkie's views on "Socialized Medicine." This present page reflects the opinions of President Roosevelt. See also additional statements which follow.

**Letter from Stephen T. Early, Secretary to
President Franklin D. Roosevelt**

In addition to the information contained in the reproduction of an editorial page from the *Rocky Mountain Medical Journal*, given on the preceding page, the following communications have been received:

(COPY *)

September 24, 1940.

Dr. George H. Kress, Secretary and Editor,
California Medical Association,
450 Sutter Street,
San Francisco, California.

My Dear Dr. Kress:

I am directed to offer you the following statement for publication in CALIFORNIA AND WESTERN MEDICINE, as quoted from President Franklin D. Roosevelt:

"There is nothing more important to a nation than the health of its people."

"Let me, with great sincerity, give the praise which is due to the doctors and nurses of the nation for all that they have done during those difficult years that lie behind us, often at great sacrifice, in maintaining the standards of care of the sick and in devoting themselves without reservation to the high ideals of their profession."

"These professions can rest assured that the Federal Administration contemplates no action detrimental to their interests."—Franklin D. Roosevelt.

Yours very sincerely,

STEPHEN T. EARLY,
Secretary to the President.

* * *

Dr. Elmer Belt of Los Angeles has requested the insertion of the following statement:

September 24, 1940.

To the Editor:—Dr. Elmer Belt, President of the California State Board of Health, presents the following facts from the thirty-fifth biennial report of the Department of Public Health of California, regarding coöperation of the Federal Administration with the Health Department of the State of California:

Through the provision of Social Security funds, services covering industrial hygiene, public health nursing, county health work, maternal and child welfare and services to physically handicapped children were undertaken by the California State Department of Health. Funds provided by the Federal Government for carrying on these undertakings totaled \$732,501.98 during the biennial period that ended June 30, 1938. All of these services maintained through the provision of federal funds under the Social Security Act were conducted the same as the routine activities of the State Department of Health. All personnel employed under Social Security come under the provisions of the State Civil Service Law. No positions under any of these public health services, financed through Social Security funds, were outside of the state civil service.

Maternal and child welfare activities were conducted within the Bureau of Child Hygiene under the general supervision of the chief of that bureau, while other activities, such as industrial hygiene, crippled children services, public health nursing, and county health work were conducted by newly organized independent services. The organization and direction of these services and the disbursement of Social Security funds was under the direction of Howard Morrow, M. D., Edward M. Pallette, M. D., William R. P. Clark, M. D., George H. Kress, M. D., Gustave Wilson, M. D., Roy A. Terry, M. D., V. A. Rossiter, D. D. S., and Walter M. Dickie, M. D.

The administration of such funds and of these services was and will continue to be under the direction of the doctors of the California State Board of Health.

These are deeds, not platform promises.

* The letter which follows was received from Dr. Elmer Belt and Associates, with the statement that it had been approved by Secretary Stephen T. Early.

EXECUTIVE COMMITTEE MINUTES

(Continued from Page 180)

Medical Association also present, and because the Bali Room is the only available meeting space for a meeting of the House of Delegates on Monday evening, it was voted that it would not be possible to grant the request of the Auxiliary for release of the Bali Room for entertainment features.

8. Los Angeles County General Hospital.

Dr. Lowell S. Goin called attention to certain problems which had arisen at the Los Angeles County General Hospital. It was agreed that it would seem to be in order for the Los Angeles County Medical Association to prepare a memorial or letter to be presented to the California Medical Association Council on October 6, in which would be outlined the principles at issue. The Council could then take up consideration of the principles involved.

9. Indemnity Defense Fund.

The Association Secretary reported on the steps that had been taken to compile an accurate listing of past and present members of the Fund; stating that up to the present time a total of 117 members had not assigned their interests (their proportion of \$10 to \$40 each) to the "Trustees of the California Medical Association." Doctor Kress read a letter which had been sent to each of these members. (The approximate amount of moneys to the credit of the savings accounts of the Indemnity Defense Fund is \$46,840. The total number of physicians who were members of the Fund is 1,433, and all but 117 of these have assigned or lapsed their interests therein to the "Trustees of the California Medical Association.")

10. Medical Exhibits at Golden Gate International Exposition.

The desirability of salving some of the medical exhibits at the Golden Gate International Exposition, which would close on September 29, for possible future use at state and county fairs, was discussed. A special committee was authorized to investigate this matter with authority to make arrangements for proper storage.

11. Adjournment.

GEORGE H. KRESS, *Secretary.*

Attest:

CHARLES A. DUKES, *Chairman.*

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS

Dr. Philip K. Gilman, Chairman of the California Medical Association Committee on Medical Preparedness, recently sent to County Society Committees on Medical Preparedness the following letter:

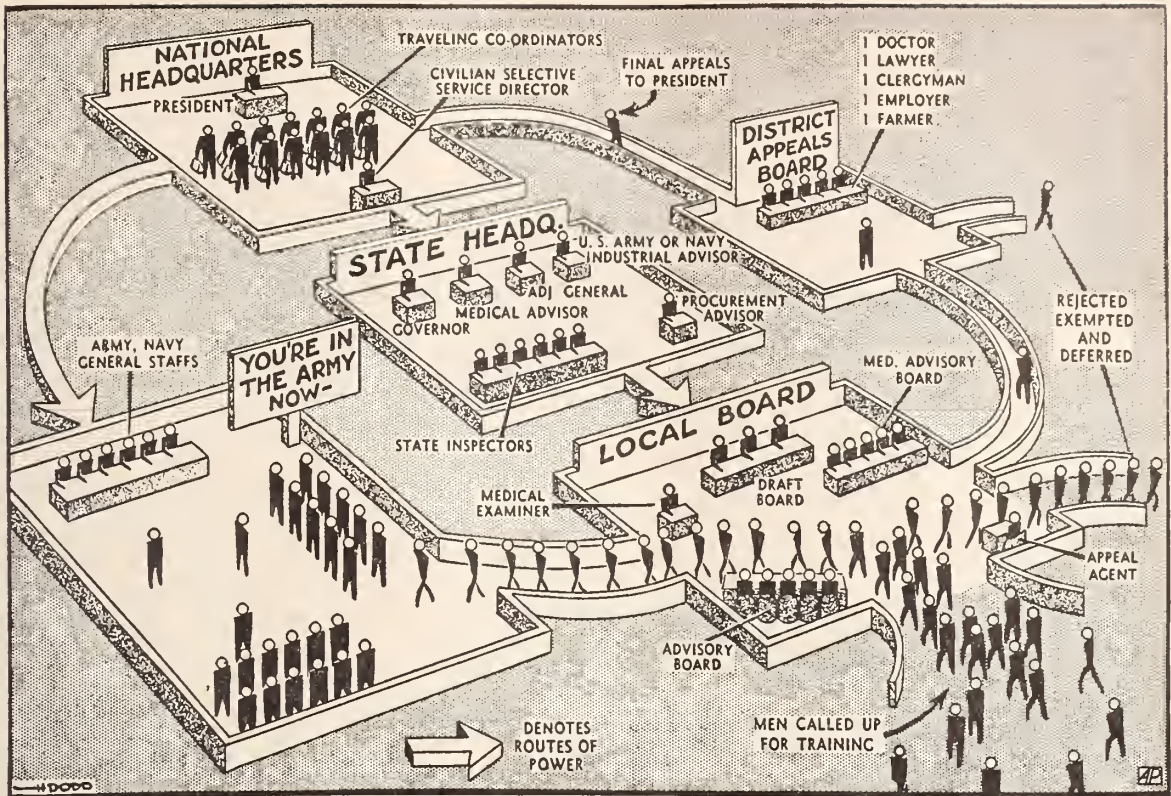
Dear Doctors:

The "Military Preparedness" sections of *The Journal of the American Medical Association* and *CALIFORNIA AND WESTERN MEDICINE*, in recent issues, have explained the progress that has been made, in securing for the Military Departments of the Government, that adequate information concerning the members of the medical profession of the United States, which is vitally necessary if the best service is to be rendered to the Army, Navy and Public Health divisions, and to the civil population as well. None of us can say when the great emergency will arise.

* * *

The American Medical Association questionnaire sent from Chicago to every physician is the means through which needed information will be obtained for the military arms of our country.

It is most important that every physician should mail his reply to the American Medical Association at 535 North Dearborn Street, Chicago, as promptly as possible.



A diagram of the conscription measure gives a picture like this. Men flow from the local draft boards to the Army and to the Navy when they are needed. Appeals flow to Appeal Boards.—San Francisco *Call-Bulletin*, September 25, 1940.

If this has not been done, or if a new questionnaire is needed, a request to the California Medical Association, 450 Sutter Street, San Francisco, will bring the proper blanks.

As chairman of the California Committee on Medical Preparedness, I am writing to you, since you are one of the county chairmen, to request you to check on the physicians in your county, and to urge all who have not done so, to send in their questionnaires. (You are at liberty to appoint as many colleagues to assist you in this work, as you may deem proper.)

With a set-up of yourself as chairman or captain, you contacting a certain number of aides or lieutenants, and they in turn each responsible for contacting, by telephone, say, ten physicians, it should be possible for you to get a fairly good estimate of the extent to which the physicians in your county have cooperated.

Dr. Charles A. Dukes of Oakland, who is one of the ten members of the American Medical Association committee, and the undersigned, go to Chicago for a meeting on September 20, at which time every state medical association will make its report.

I am hoping to make a good report for California, and with your help it will be possible. Without your prompt cooperation, I shall be in an embarrassing position. I am counting on your aid.

For your convenience, I am enclosing a blank on which you can make at least a tentative report. Reply envelope is also enclosed.

Your report should be in my hands in San Francisco not later than Saturday, September 14, because Doctor Dukes and I leave for the East on Tuesday, September 17.

May I not hope to hear from you as promptly as possible? With thanks for your cooperation in this important work, I am

Cordially yours,

(Signed): PHILIP K. GILMAN, M. D.,
Chairman, California Committee on
Medical Preparedness.

It is hoped that the members of the California Medical Association who have not sent their questionnaire replies to the American Medical Association Committee on Medical Preparedness, 535 North Dearborn Street, Chicago, Illinois, will do so. If the reply blank has been misplaced, a request for a duplicate set should be sent to the California Medical Association Committee on Medical Preparedness, 450 Sutter Street, San Francisco.

* * *

(COPY)

CALIFORNIA MEDICAL ASSOCIATION

San Francisco, September 23, 1940.

To the Councilors, Presidents, and Secretaries of County Medical Societies:

Dear Doctors:

At the recent joint meeting of the Trustees of the American Medical Association, the Committee on Medical Preparedness of the American Medical Association and the Chairmen of the State Committees on Medical Preparedness held in Chicago, September 20, 1940, at which meeting also representatives of the Medical Corps of the Army, Navy, and Public Health Service were in attendance, many important subjects relative to medical preparedness were discussed. A synopsis of this meeting will appear in an early issue of *The Journal of the American Medical Association*.

Matters considered in order of their importance were as follows:

1. *Completion of the questionnaires.* This is particularly important in relation to physicians in the draft age. We advise and urge early completion of these questionnaires and believe that doctors who are in the draft age should volunteer, so that their classification as to qualifications would place them in a preferable position in the preparedness program. Should such an emergency arise, the above

procedure would certainly lessen confusion in the placement of medical officers.

2. *All physicians, whether in the draft age or not, should complete their questionnaires at once*, so that those in special groups may be properly placed when and if the Government requires their services.

Physicians neglecting to send in their questionnaires will necessarily be classified according to the information carried in the American Medical Association Directory. This information being less complete than that contained in the questionnaire may lead to confusion, faulty classification, and undesirable placement.

* * *

Methods to secure the return of the questionnaires were discussed at this meeting and the following are suggested to county medical societies:

- (a) By return postal card;
- (b) By local committee;
- (c) By telephone requests.

Owing to the urgency of the situation, immediate personal visits or telephone requests are recommended.

It is suggested that use be made of the Woman's Auxiliary to aid you. The Auxiliary has offered to cooperate in any manner requested.

We, therefore, cannot urge you too strongly to see that each member, who has not already done so, immediately complete and forward his questionnaire.

An immediate reply to this letter is requested. Address: California Medical Association Committee on Medical Preparedness, 450 Sutter, San Francisco.

Sincerely yours,

C. A. DUKES,
*Member, Committee Medical Preparedness
American Medical Association.*

P. K. GILMAN,
*State Chairman, California Committee on
Medical Preparedness.*

* * *

Medical Participation in Selective Service*

By CHARLES B. SPRUIT

Lieutenant Colonel (M. C.), General Staff Corps, United States Army; Medical Adviser to the Joint Army and Navy Selective Service Committee Washington, D. C.

THE RÔLE OF THE PHYSICIAN

... Inauguration of selective service brings a new responsibility to the medical profession and another opportunity of service to the nation. The rôle of the physician in the Selective Service mechanism will be to examine, to find, to evaluate and to recommend. The local board and the appeal board will determine the final classification of all registrants. It is believed that the participation of the physician of the community in determining the physical qualifications of registrants will promote confidence in the fairness of the system and permit of a more accurate determination of the ability of a man to perform military service. The intimate knowledge that the local physician has of the members of his community should be of marked assistance not only in the determination of physical fitness, but also in the detection of malingering on the part of men seeking to evade service. . . .

THE LOCAL EXAMINING PHYSICIAN

The physical examinations of Selective Service will be made by local examining physicians, who act as agents of the local boards for this purpose. When necessary, additional examining physicians may be appointed by the

local board. The local examining physician will examine all registrants sent to him by the local board according to the standards of physical examination which will be furnished him. He will note all deviations from the normal on physical examination forms and then interpret them in the light of the physical standards and in terms of the ability of the registrant to perform full military service. Thereafter he will record his recommendations to the local board as to the physical qualifications of the man to do full or limited military service. If the registrant possesses defects that disqualify him for any military service, that fact, likewise, will be entered. In those cases in which the local board has appointed additional examining physicians, it may be feasible in certain communities to form an examining group to facilitate and expedite the examinations.

MEDICAL ADVISORY BOARDS

Medical advisory boards will be appointed by the President, on the recommendation of the state, to provide an agency of advice and assistance to examining physicians and to assist appeal boards in determining matters of physical fitness which have been appealed from the decision of the local board by the registrant or by the Government agent. The medical advisory boards will as far as practicable comprise internists, ophthalmologists, otolaryngologists, orthopedists, surgeons, psychiatrists, clinical pathologists, radiographers, and dentists.

MALINGERING

The experience of Selective Service during the last war showed the necessity of constant vigilance to detect malingering. Many men descended to self-mutilation and numerous other more ingenious but less harmful subterfuges to escape military service. Malingerers will doubtless be encountered in the coming operation of Selective Service. Regulations on physical standards mention many of the more common practices used by malingerers to feign disability and describe methods by which these may be detected.

THE MEDICAL TASK

The fall increment of some 400,000 men will be distributed according to quotas to the several states and by each state headquarters to the local boards in that state. On the assumption that these 400,000 men will be equally divided among the 6,500-odd local examining boards, and utilizing the World War percentage of rejections by examining physicians of Selective Service and of the Army, there will be about ninety men per local board for physical examination. As these men will not all be inducted immediately but will be called up during the following three or four months, the average examination load on each board will probably be between twenty and thirty men per month. These calculations are not applicable to each local board because the quota assigned to a local board takes into consideration certain credits to that community accruing from men presently in the regular services or active National Guard. The total appeals on physical grounds during the World War indicate a lesser load on medical advisory boards. The additional number of cases sent up for advice by local examining physicians is not known.

STATE HEADQUARTERS

The state headquarters operating under the governors of the several states are charged with the organization and operation of the Selective Service system within the respective states under the policies and procedures authorized by the President. For each state the President will designate one or more officers of the Medical Reserve Corps of the Army and Navy as medical assistants on the staffs of the several governors. They will assist the state authorities in the supervision and coordination of medical examinations throughout the state. They will establish

* The following are excerpts from an article in *The Journal of The American Medical Association*.

and maintain liaison with all examining physicians and members of medical advisory boards, hold regional meetings for them to promote critical discussion and analysis of the medical problems of selective service, and visit medical advisory boards, local boards, and examining physicians to advise and assist all concerned with physical examinations. They will keep the necessary records and statistical analyses of the operation of the medical function of Selective Service within the state.

NATIONAL HEADQUARTERS

The National Selective Service Headquarters in Washington will contain a compact medical division, which will assist the director of Selective Service in the determination of policy on medical matters and have general direction and coordination of the medical functions through the state headquarters and the medical assistants in each state. . . .

* * *

Nominations for Registration Board Members Sent to Washington by Officials

Los Angeles County moved swiftly yesterday in its efforts to aid the Government in conscripting America's first peace-time Army.

Superior Judge Peirson M. Hall, representing Governor Olson, announced that all registration boundaries have been officially fixed, added that he and his associates have been accorded "gratifying cooperation on all sides" and congratulated county officials for prompt measures in setting up preliminary draft machinery.

"This," said Judge Hall, "will aid us quite materially when we come to draft day on October 16. All this preparatory work, performed ungrudgingly and in a fine spirit of patriotism, has been of inestimable value to those in charge of the initial steps."

SERVE CHEERFULLY

Judge Hall, checking off various points in his daily agenda, said:

"Nominations of those who may serve on the draft and appeal boards have not only been completed, but the various nominees have been contacted and, in every case, have cheerfully agreed to serve.

"Although we are not positive whether three or five members will be expected to serve on the draft boards, we have, in every instance, certified six names to Washington. Thus they may choose at their own discretion.

"In the case of the appeal boards, we sent in lists of five, for the same reason.

AHEAD OF SCHEDULE

"Each draft board will have its own medical adviser and alternates. Medical advisers for the appeal boards will be nominated by the State Medical Association.

"There also will be advisory boards of thirty, with chairmen designated by Governor Olson, to assist draftees in filling out their questionnaires.

"All these, of course, will serve without pay, and all those contacted thus far have readily agreed to do so. On the whole, the draft machinery, as far as this country is concerned, is not only moving on time, but is ahead of schedule. There should be little friction when the actual registration starts."

Judge Hall, working with Adjutant-General R. E. Mittelstaedt and other California representatives, pointed out that the "utmost publicity will prevail throughout the draft, as well as during its preliminary steps," and predicted that the ensuing training will be conducted on a basis satisfactory to all.

"One point in particular should be stressed," Judge Hall continued, "and this is the fact that the success of this great defense program depends upon the men themselves.

"By this, I mean that the men selected for service must have a healthy reaction to camp life or the whole structure is endangered."

He explained that, with this in mind, the Federal Government will see to it that few, if any, men will be called into service until adequate preparations have been made by the Army to care for them properly. This, he indicated, takes into consideration ample camp facilities, clothing, food, and and all necessary items in camp routine. . . .—Los Angeles Times, September 20.

* * *

Health Board Appointed—Group to Coöperate in Defense Program Headed by Kentuckian

Washington, September 19 (AP).—President Roosevelt named today a committee to coöperate with the Defense Commission on all phases of public health as an additional means of strengthening the nation for any emergency.

Under the authority of an act of 1916, he named five men "to advise the Council of National Defense regarding the health and medical aspects of national defense and to coordinate health and medical activities affecting national defense."

Named as chairman was Dr. Irvin Abell of Louisville, Kentucky, chairman of the Board of Regents of the American College of Surgeons.

OTHER MEMBERS

The other members of the Medical Advisory Committee are Dr. Lewis H. Weed, Chairman of the Division of Medical Sciences of the National Research Council; Rear Admiral Ross T. McIntire, Navy Surgeon-General and White House physician; Major General James C. Magee, Army Surgeon-General; and Dr. Thomas Parran, Surgeon-General of the United States Public Health Service.

McIntire, explaining the President's action to reporters, said probably 16,000 additional physicians will be needed to handle 900,000 prospective conscripts. There are about 180,000 members of the medical profession in the country, he continued.

PROPER SPREAD

Every effort will be made, he said, to see that there is a "proper spread" of surgeons and nurses, and the question of correlating health and defense problems will be handled in a "careful way" so as "not to upset the civilian side" of medical care.

In the World War, he said, the country mobilized primarily to send an army overseas.

"Today," McIntire asserted, "we are thinking of getting the whole country ready to take care of itself. So, the medical profession has been looking ahead to the proper distribution of hospital beds, nurses, doctors, and medical facilities."

For two months, he said, the American Medical Association has been making a survey of its members to get an idea what they could do and would like to do to coöperate with the preparedness program. About 100,000 answers to questionnaires have been received, he added.—Los Angeles Times, September 20.

* * *

University of California Naval Medical Unit Prepared to Battle Plagues

In the midst of eleventh-hour national defense preparations, with many people wondering whether America can get ready for a total war impact within the next year or so, the University of California and the Navy Department announce that they are ready immediately to put a

fully trained, fully equipped medical laboratory unit in the field for the purpose of studying and controlling epidemics in mobilization camps and elsewhere. The unit has been in training for seven years under the direction of Dr. A. P. Krueger, professor of bacteriology and commanding officer of the unit, who was recently selected for promotion to the rank of commander in the navy. Second in command is Dr. Robert Alan Hicks of Tucson, Arizona. Each member of the unit enters the organization as a chief naval petty officer.

Foresight in providing for this vital unit seven years ago is credited to Admiral Rossiter, surgeon-general of the navy in 1934, and to Doctor Krueger, who suggested the unit to Admiral Rossiter. One of its principal advocates at the present time is Dr. Ross McIntire, personal physician to President Roosevelt and present surgeon-general of the navy.

The unit is the first of its kind in the United States and is known as Naval Laboratory Research Unit No. 1. Some time ago a second unit was formed in the East. The fact that the navy now has this group of specially trained medical men means that in any possible concentration of navy men under the conscription bill or otherwise, the development of epidemics and other rampant infections will be investigated at the start, thus insuring that a maximum number of effectives will be kept available for actual naval service.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Under the auspices of the Committee on Public Health Education, notices to renew interest in the essay contest on "The Role of the Doctor of Medicine in the Life and Health of the American Citizen," have been sent during the past month to 575 high schools, junior colleges, parochial schools, and private schools. This contest closes in November and efforts are being made to get all replies possible in on time.

Inquiries from contestants in the scenario contest, which is preliminary to the motion picture to depict the scientific advancement and achievements of doctors, have been answered and the proper entry blanks forwarded to those seeking to enter the contest.

Ninety-one chairmen of Adult Education Forum discussion groups in California evening high schools have been notified that doctor-speakers are available to appear before their groups and they have been given a list of the forty California Medical Association Speakers' Bureaus secretaries so they will know where to request speakers.

Lists of the adult forum discussion groups with their addresses have been sent to the forty secretaries of the Speakers' Bureaus to enable them, if they can do so, to arrange to place their speakers before the discussion forums in their vicinities.

Requests for speakers have been received from various parts of the state for dates as far ahead as next May and the Committee on Public Health Education, through its public relations counsel, will arrange at the proper times with speakers' bureaus to provide speakers for these dates.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Gohn, Los Angeles; Julius B. Harris, Sacramento; Harry H. Wilson (ex officio), Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 403 South Spring Street, Los Angeles (telephone TUCKer 2312), or 244 Kearny Street, San Francisco (telephone YUKon 2212).

One state-wide publicity story has been issued during the past month regarding the essay and the scenario contests and, now that the summer season is over, more stories will follow when actual news value warrants. It may be pointed out that publicity at this time is a difficult problem, owing to the great demand for space for war news and the political campaign.

Your Public Relations Counsel spoke at the postgraduate meeting of the Eighth District at Lake Tahoe on August 25, explaining the work of the Committee.

During the month your Public Relations Counsel has conferred with the legal department and representatives of the Public Health League concerning the Basic Science Initiative and is giving full assistance in the plans for this important activity.

R. M.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Third Councilor District (Kern, San Luis Obispo, Santa Barbara, and Ventura Counties) the First Councilor District to Inaugurate Councilor Postgraduate Conferences

In the September issue (page 106) the Eighth Councilor District was referred to as having been the first councilor district to inaugurate a postgraduate conference. That statement was in error because the honor belongs to the Third Councilor District, as may be noted by perusal of the letter which follows, received from Dr. Louis A. Packard, Councilor of the Third District, who gave much effort in promoting the successful conferences held at Bakersfield and Santa Barbara.

Doctor Packard's letter follows:

Bakersfield, California,
September 12, 1940.

Dear Doctor Kress:

I noted with interest your comment in CALIFORNIA AND WESTERN MEDICINE, in the September issue, on Councilor District Postgraduate Conferences; and note particularly that you say: "To the Mother Lode Councilor District . . . will belong the honor of having been the first of the nine Councilor Districts of the California Medical Association to have proposed and carried through to a successful conclusion a postgraduate conference for the members of the component county societies included in its councilor territory."

In the article following, still devoted to the subject you state: "Query: Which of the other eight councilor areas will be the first to follow the example set by the Mother Lode Eighth Councilor District?"

Please recall that in 1938, 1939, and 1940 the Third Councilor District has held a Third District Conference; in 1938 and 1939 in Santa Barbara, and in 1940 in Bakersfield; that all of these have been for and by the constituent counties of the Third District and that the average attendance for the two days has been in excess of one hundred. While it is too early to give any definite information, I feel quite certain that the fourth annual conference of the Third District will be held in 1941. I am sure you will recall at least the 1940 meeting since you were present at that time.

The session held at Tahoe appeared to be a very well prepared one and only the fact that I was out of the State at the time prevented me from attending. I suggested this type of a conference to the Postgraduate Committee at Coronado and described to them the district conference we had held. This conference at Tahoe, I think, was the first to be held in the State along the lines of our Third District meetings.

With kindest regards, I am

Sincerely yours,

LOUIS A. PACKARD, M. D.,
Councilor, Third District.

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

The much discussed basic science law for California is on the road to completion. In 1939 the Committee on Public Relations gave much thought to the proposed initiative law, making three revisions thereof. Much aid was received from W. C. Woodward and J. W. Holloway, Jr., of the American Medical Association Bureau of Legal Medicine, that Bureau having had considerable experience in the drafting of most of the basic science laws that are now in operation. The decisions reached by the Committee on Public Relations in 1939 and 1940 were incorporated into the proposed law by the legal department of the California Medical Association, through Legal Counsel Peart and his associate, Mr. Hassard.

The fourth draft, which may be said to be almost the final draft of the proposed law, is now under consideration by professional groups affiliated with medicine. It is hoped that, on or before November 1, 1940, it will be possible to submit the final draft to the Attorney-General of California for title. Once the title is received, it will be in order to print the petitions for signatures of voters. At the present time, a total of 212,000 valid signatures are necessary to qualify a proposed initiative for place on a state ballot. Because a large number of signatures are found to be invalid (see CALIFORNIA AND WESTERN MEDICINE, August 1940, on page 56, for comments concerning signatures), it has been found necessary to have at least 100,000 additional signatures over and above the stipulated number. It is possible that the basic number of 212,000 may be increased, depending upon the number of voters who go to the polls in the presidential election in November, 1940.

Once the procedures noted above are completed, component county medical societies and members of the Association will receive additional information concerning the work ahead.

CALIFORNIA PHYSICIANS' SERVICE*

California Physicians' Service beneficiary memberships have reached a total of 17,400 dues-paying members during the month of September, in approximately 625 groups.

A program of expansion in the San Joaquin Valley was inaugurated on September 24 with a dinner meeting, at which the Fresno County Medical Society acted as host to 160 business men, civic leaders, physicians, and others. The dinner was planned by the County Medical Society as a means of introducing the idea of California Physicians' Service to business men and community leaders. Dr. Dewey R. Powell of Stockton, a member of the Board of Trustees

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

*Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone: EXbrook 3211. Alson Kilgore, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

of California Physicians' Service, described to the group the intent behind the movement on the part of the medical profession and warned against "regimentation of compulsory medical service," pointing out that physicians themselves are the ones best fitted to meet the medical needs of the community. Mr. J. Philo Nelson, general manager of the service, from San Francisco, described the progress of nonprofit hospital plans throughout the country, and described in considerable detail the protection offered through California Physicians' Service and the nonprofit hospital associations.

As previously announced, Mr. H. B. Rector is now located in Fresno as Field Representative for the entire San Joaquin Valley area, with headquarters in the T. W. Patterson Building.

The study of statistics referred to in previous issues continues, and will be reported upon in considerable detail in the near future. We find that during the month of May, when there were 5,112 professional members in the state, that 1,057 doctors, or 20.6 per cent of the professional members, participated. There were 10,514 units of service rendered, for which \$13,142.50 was disbursed to physicians, at a unit value of \$1.25, which represents an average of \$12.43 per professional member.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (44)

Alameda County (1)

Kenelm Winslow Benson, *Berkeley*

Lassen-Plumas-Modoc County (1)

Herman Swartzman, *Belden*

Los Angeles County (27)

Frank Manter Anderson, *Los Angeles*
Maynard S. Bourdeau, *Glendale*
Ernest George Burrows, *Inglewood*
Edwin S. Chapmann, *San Fernando*
Harold Arnold Cohn, *Los Angeles*
Hyman Engelberg, *Los Angeles*
Rygel E. Farrand, *Pasadena*
W. Arden Fate, *Los Angeles*
Paul Hanson, *San Marino*
Horace W. Jamison, *Los Angeles*
Harry E. Kerber, *Glendale*
Monroe Franklin Loy, *Los Angeles*
Harold J. Magnuson, *Los Angeles*
Harold R. Ostrander, *Los Angeles*
Max Edward Pohlman, *Los Angeles*
Henry Salvatore Portogallo, *Los Angeles*
Charles Edward Romaly, *Los Angeles*
Norman Reider, *Los Angeles*
Maurice B. Rogers, *Los Angeles*
Eugene Rosenman, *Los Angeles*
Lewis F. Seapy, *Long Beach*
Edward Shapiro, *Los Angeles*
Ludwig Strauss, *Los Angeles*
Wendell W. White, *Los Angeles*
John C. Wilcox, *Pomona*
Geoffrey Williams, *West Los Angeles*
N. John Zahry, *Los Angeles*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Concerning absence in this issue of letters from county societies, see comment on page 154.

San Diego County (4)

James D. Edgar, *San Diego*
 Morris John Kotler, *San Diego*
 John A. Norton, *Oceanside*
 Lawton E. Shank, *San Diego*

San Francisco County (6)

Robert B. Alexander, *San Francisco*
 Charles C. Impey, *San Francisco*
 Jesse J. Iverson, *San Francisco*
 Malcolm C. Johnson, *San Francisco*
 Karl A. Reed, *San Francisco*
 Maurice Sokolow, *San Francisco*

Shasta County (3)

John D. Briggs, *Weaverville*
 Roland R. Jantzen, *Redding*
 Harold R. Whiteside, *Redding*

Solano County (1)

Arnold Houser, *Vallejo*

Yuba-Sutter-Colusa County (1)

David Frost, *Williams*

Resigned (1)

Harvey M. Slater, from Santa Clara County.

Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Schwuchow, Walter Bernard. Died at Los Angeles, September 3, 1940, age 62. Graduate of Rush Medical School, University of Chicago, 1903. Licensed in California in 1911. Doctor Schwuchow was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Sullivan, William Reginald. Died at Merced, September 3, 1940, age 30. Graduate of the University of Kansas School of Medicine, Kansas City, 1935. Licensed in California in 1936. Doctor Sullivan was a member of the Merced County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Whiteside, Harold Rowland. Died at Sacramento, September 8, 1940, age 36. Graduate of the University of Oregon Medical School, Portland, 1933. Licensed in California in 1934. Doctor Whiteside was a member of the Shasta County Medical Society, the California Medical Association, and the American Medical Association.

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In Memoriam

OBITUARIES**William Wesley Fitzgerald**

1868-1940

Burns, Ernest Madison. Died at Huntington Park, August 20, 1940, age 47. Graduate of the University of Nebraska College of Medicine, Omaha, 1921. Licensed in California in 1923. Doctor Burns was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Clarke, Austin Fisher. Died at Oakland, August 18, 1940, age 68. Graduate of Kentucky School of Medicine, Louisville, 1892. Licensed in California in 1893. Doctor Clarke was a member of the Alameda County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Cowles, Danforth C. Died at Fullerton, August 28, 1940, age 64. Graduate of the University of Minnesota Medical School, Minneapolis, 1901. Licensed in California in 1916. Doctor Cowles was a member of the Orange County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

+

Jennison, John Egbert. Died at San Diego, August 19, 1940, age 72. Graduate of the University of Minnesota Medical School, Minneapolis, 1894. Licensed in California in 1909. Doctor Jennison was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

+

Rosenberger, Homer G. Died at Los Angeles, August 13, 1940, age 60. Graduate of Rush Medical College, University of Chicago, 1907. Licensed in California in 1908. Doctor Rosenberger was a member of the Los

Joaquin County Medical Society, passed away at Stanford Hospital in San Francisco on July 7, 1940, of a pulmonary embolism after apparently convalescent from a laparotomy or intestinal complications due to amebic dysentery.

Doctor Fitzgerald was born about seven miles east of the city of Stockton on June 1, 1868, the son of a pioneer who had located in this section in 1851 and who planted the first vineyard and orchard in the Linden district.

Doctor Fitzgerald was graduated from the Jefferson Medical College in Philadelphia in 1895. In the same year he returned to Stockton and was licensed to practice.

Doctor Fitzgerald's wide acquaintance in his native city, his very unusual professional ability, and his charming personality won him a tremendous practice. His friends were fascinated by his recital of the problems of early-day practice in the pre-automobile era, when relays of horses were necessary to maintain the strenuous pace that the busy practitioner of that day had to keep up. The Doctor was always thoughtful and considerate of the younger men in practice.

Doctor Fitzgerald was surgeon for the Southern Pacific Railroad, and his many trips to Southern California made him interested in walnut culture. He believed that the climate and soil of San Joaquin County were adaptable to walnut growing and began a very intensive study of this problem. He crossed the English walnut onto the black walnut and established a commercial grove of sixty acres in 1909 and another grove of 100 acres in 1915. He was indeed a pioneer in the horticultural development which has meant much to this area in subsequent years.

When he retired from active professional work in 1918, his interest in walnut culture was indeed a life-saver for him. He maintained that interest continuously in the prob-

lem and was often sought out for advice, and lectured before many organizations on walnut-growing.

Down through the years Doctor Fitzgerald maintained a continuing interest in medical problems and in organized medicine even though he was no longer in practice. He manifested a keen interest in the California Physicians' Service and demonstrated that interest by sending in his \$5 membership fee as an expression of good will even though he knew he would never qualify as a professional member in active practice.

Those of us who knew and valued Doctor Fitzgerald through the years as a friend and a confrère will miss his genial smile and his gracious personality. The members of the San Joaquin County Medical Society extend to his surviving widow their sincere sympathy in her great loss.

D. R. P.

+

Edmund Frost
1881-1940

The members of the San Joaquin County Medical Society were shocked and grieved to learn on the evening of June 26, 1940, of the sudden death of Dr. Edmund Frost.

Doctor Frost had been busily engaged in his usual professional activities at the hospital and office throughout the day and was stricken with a fatal heart attack at his home that evening.

Edmund Frost was born at Birkenhead, England, on November 10, 1881, and received his education in that country, where he received his degree in civil engineering from Yorkshire College at Leeds, England. He came to the United States in 1912 and received his medical training in the College of Physicians and Surgeons in San Francisco, graduating in 1917. He interned in the Stanford Service at the San Francisco County Hospital and spent two years as resident physician at the Santa Clara County Hospital.

During his nineteen years of residence in our city, Doctor Frost won many friends among the profession and the laity whom he served, by his quiet and gentlemanly demeanor and his conscientious attention to his professional responsibilities.

The members of this society extend to his widow and children their very sincere and heartfelt sympathy in their great loss.

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Robert Beverly Taylor
1906-1940

On September 15 the friends and associates of Dr. Robert Taylor were shocked to learn of his tragic death after being thrown from his horse while riding in Golden Gate Park. Doctor Taylor was only thirty-three years of age, and for the past six years had been in general practice and assisting his father, Dr. Charles Taylor, at his offices at 450 Sutter Street.

Born in San Francisco and a graduate of Lowell High, Doctor Taylor attended Stanford and received his M. D. from Creighton Medical School in Omaha, Nebraska, in 1933. He then returned to San Francisco, where he remained from that time, with the exception of a postgraduate year in Vienna in 1937.

Although in general practice, Doctor Taylor had planned to become a surgeon like his father, with whom he worked as an assistant at Dante Hospital. His untimely death while pursuing his favorite sport has cut short prematurely a promising career, and the sincere sympathy of the Society has been extended to Dr. and Mrs. Charles Taylor, his parents, in their great loss.

H. M. F. B.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN.....Asst. Chairman on Publicity

Meeting of Board of Directors

A record attendance of thirty women greeted the new state president, Mrs. A. E. Anderson of Fresno, when she met with her Board of Directors in an all-day session at the Lake Merritt Hotel in Oakland on Friday, September 13. All the officers and councilors-at-large were present, as were six of the nine district councilors. In addition there were thirteen of the twenty-eight county presidents in attendance at the meeting.

Officers.—Mrs. A. E. Anderson of Fresno, president; Mrs. Harry O. Hund of San Rafael, president-elect and chairman of finance; Mrs. F. G. Lindemulder of San Diego, first vice-president and chairman of membership and organization; Mrs. Harry G. Huffman of Santa Ana, second vice-president and chairman of program and health education; Mrs. R. K. Cutter of Berkeley, recording secretary; Mrs. E. R. Scarboro of Fresno, corresponding secretary; and Mrs. C. G. Stadfield of Los Angeles, treasurer.

Councilors-at-Large.—Mrs. A. A. Alexander of Piedmont, chairman of public relations; Mrs. William C. Boeck of Beverly Hills, chairman of publicity; Mrs. Louis A. Packard of Bakersfield, chairman of *Hygeia*; and Mrs. John C. Sharp of Salinas, convention chairman.

District Councilors.—Mrs. G. W. Coon of Riverside, First District; Mrs. Franklin Farman of Los Angeles, Second District; Mrs. Richard McGovney of Santa Barbara (absent), Third District; Mrs. J. C. McClure of Lindsay (absent), Fourth District; Miss Julia Koenecke of Salinas, Fifth District; Mrs. Eugene Kilgore of San Francisco, Sixth District (also chairman of public relations); Mrs. Charles C. Hall of Piedmont, Seventh District; Mrs. E. O. Brown of Sacramento (absent), Eighth District; and Mrs. Frank A. Lowe of San Francisco, Ninth District.

Mrs. Arthur Newcomb of Pasadena, historian, and Mrs. L. R. Willson of Fresno, parliamentarian, were absent.

The following presidents of county auxiliaries were present: Mrs. Ira Church of Alameda County, Mrs. Kaho Dailly of Contra Costa County, Mrs. C. C. Landis of Butte County, Mrs. Ralph B. Eusden of Los Angeles County, Mrs. Lloyd G. Tyler of Marin County, Mrs. Ralph M. Smith of Riverside County, Mrs. George Briggs of Sacramento County, Mrs. G. H. Rohrbacher of San Joaquin County, Mrs. P. J. Hanzlik of San Mateo County, Mrs. Philip Haley of Santa Clara County, Mrs. A. J. Pederson of Santa Cruz County, Mrs. H. Randall Madeley of Solano County, and Mrs. A. E. Ghilotti of Stanislaus County.

Mrs. Anderson, President, presented her splendid program of aims, plans and projects for the year 1940-1941. This was received with enthusiasm and is printed herein. Committee chairmen all presented well-worked-out programs, and the alert spirit which prevailed throughout the meeting showed that the year is off to a flying start. Effort is to be directed toward increased membership and the organization of new county auxiliaries; toward increased circulation of *Hygeia*, the chief duty that the

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 2435 Nottingham Avenue, Los Angeles. Address of the Chairman on Publicity: Mrs. William C. Boeck, 712 North Maple Drive, Beverly Hills.

For roster of officers of state and county auxiliaries, see advertising page 6.

American Medical Association asks of the Auxiliary; toward public health work through various channels in contact with the public. The *Courier* is to be published in October and April; subscriptions to the *Bulletin*, the national Auxiliary publication, were urged; and plans are well under way for the convention at Del Monte in May, 1941.

Mounting activity of all committees was evidenced by the unanimous decision to purchase a mimeograph with which to lighten the load of the many identical letters, outlines of plans and instructions which must go out to the twenty-eight county auxiliaries, not only from the president, but also from the various state committee chairmen. The mimeograph is to be in the charge of the corresponding secretary, each committee chairman to be responsible for cutting her own stencil and forwarding that to the corresponding secretary with requests for copies.

A delightful luncheon in the dining room, overlooking Lake Merritt and the Piedmont hills beyond, was arranged by Mrs. Charles C. Hall, a Board member from Alameda County.

At the close of the meeting the entire group motored to the hillside home of Mrs. Hobart Rogers, former state president, for a beautiful tea hour. Mrs. Rogers was assisted by Mrs. William H. Sargent, also a former state president; Mrs. Frank Baxter, former State Board member; Mrs. George Calvin, former Alameda County president; and by other members of the Alameda County Auxiliary.

Plans and Projects for 1940-1941

By MRS. A. E. ANDERSON, *President*

1. To never forget that we are working at all times under the approval and advice of the Council of the California Medical Association.

2. To always keep in mind the objects of the Auxiliary as stated in Article II of the Constitution: "The objects of this Auxiliary are: to bring its members into more active affiliation with organized medicine; to encourage kindly social relationships; to cooperate with the California Medical Association and its component county societies, and other organizations in all desirable public health and social welfare work."

3. To secure the active cooperation of every county unit.

4. Above all, to have a smooth-running organization to more efficiently accomplish the aims and ideals of the Woman's Auxiliary.

5. To increase the efficiency of the county auxiliaries by having group meetings of all the nine districts. At these meetings to have the officers and chairmen of standing committees of the component county auxiliaries present; to have round-table discussions of problems of the counties; if possible to have a member of the State Board, in addition to the President, to lead these discussion groups.

6. To advocate, as is done in many states, the annual physical examination of doctors' wives. (I believe this would lead other women of great timidity to do the same and thereby prevent many of the tragedies of the middle years.)

7. To aid in the work of the Philanthropic Committee of the California Medical Association in promoting the fund for the aid of the needy and unfortunate members of the profession, as provided in Resolution No. 33, passed by the House of Delegates in May 1940 at Coronado.

8. To promote *Hygeia*.

9. To urge members to commit to memory the platform of the American Medical Association, as urged by its president, Dr. Nathan Van Etten.

10. To pledge cooperation with Dr. Philip K. Gilman, the Chairman of the California Committee on Medical Preparedness for National Defense, in whatever he asks the Auxiliary to do.

11. To cooperate with the National President and National chairmen of committees in advancing the work of the Woman's Auxiliary.

By striving humbly to follow these aims with tolerance for the ideas of others and charity for our neighbors, we may attain our goal of helpfulness to our State and National Medical Association.

NEVADA STATE MEDICAL ASSOCIATION

C. W. WEST, Reno.....President
H. A. PARADIS, Sparks.....President-Elect
HORACE J. BROWN, Box 698, Reno.....Secretary-Treasurer

Official Call: Annual Session

To the Officers and Members of the Nevada State Medical Association:

The thirty-seventh annual session of the Nevada State Medical Association will be held at Las Vegas on October 10 to 12, 1940.

All active and honorary members are cordially invited to be present, as well as others who receive this notice.

Headquarters will be at the Elks Club, and the secretary of the Entertainment Committee, John R. McDaniel, Jr., will make hotel reservations for all those who wish them.

C. W. WEST, *President*.

Attest:

HORACE J. BROWN, *Secretary-Treasurer*.

Injection Treatment of Hernia Not Advisable for General Use.—The injection treatment of hernia is not advisable for general use and should be employed only by those with special experience and with full understanding of the dangers involved, the Council on Pharmacy and Chemistry of the American Medical Association warns in *The Journal of the Association*.

The Council's statement confirms a previous opinion based on the results of a questionnaire which was sent in 1936 to a selected list of hospitals throughout the country in order to obtain information as to the extent of the use of the injection treatment for hernia, its safety and effectiveness, the incidence of unfavorable complications and the nature of these complications. To keep the Council's information up to date, the same questionnaire has been addressed again to those hospitals which replied to the first one.

After consideration of the second hospital survey and the reports in the recent literature, the report says, "the Council now concurs in the opinion that the method involves less danger of serious complications than surgery when employed only in selected cases of hernia by those skilled in the injection of suitable standardized solutions of known composition and action. The Council is not, however, willing to recognize any such solutions for New and Nonofficial Remedies until sufficient follow-up experience in their application has been gained to establish the success of the injection method of treatment. Present evidence indicates that better types of solution are to be desired."

Never attempt to bear more than one kind of trouble at once. Some people bear three kinds—all they have had, all they have now, and all they expect to have.—Edward E. Hale.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 5-8, 1941.

American Medical Association, Cleveland, Ohio, June 2-6, 1941.

American College of Physicians, Statler Hotel, Boston, April 21-25, 1941.

American College of Surgeons, Chicago, October 21-25, 1940.

Medical Broadcasts.*

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KTMS	Santa Barbara
KFSD	San Diego	KEX	Portland
KGO	San Francisco	KJR	Seattle
	KGA	Spokane	

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of October is as follows:

Wednesday, October 2—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 5—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 9—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 12—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 16—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 19—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 23—KECA, 11:15 a. m., The Road of Health.
 Saturday, October 26—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.
 Wednesday, October 30—KECA, 11:15 a. m., The Road of Health.

Vitamin Chart.—Copy of a revised Weston-Levine Vitamin Chart has been received from Roe E. Remington, Professor of Nutrition, Medical College of the State of South Carolina, Charleston, South Carolina. Copies are for sale at ten cents each.

Physicians who are interested will find the chart to be convenient.

† In the front advertising section of *The Journal of the American Medical Association*, a different roster of national officers and organizations appears each week, each list being printed in revised form about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Government to Need Temporary and Part-Time Civilian Medical Officers.—The expansion of the army creates a need for about six hundred civilian medical officers in various grades for temporary and part-time service. The duties of full-time officers will be to act as doctors of medicine in active practice in hospitals, in dispensaries, and in the field. The duty of part-time officers will be to report for sick call at a fixed hour each day and to be subject to emergency call at all times.

The Civil Service Commission in making this announcement calls particular attention to the fact that part-time officers will be able to continue their regular practice. In order that this may be done, appointments to the part-time positions will be made of medical officers in the vicinity of the place of duty.

Information concerning these positions may be obtained from the secretary of the Board of United States Civil Service Examiners at any first- or second-class post office, or from the United States Civil Service Commission, Washington, D. C. Physicians are urged to apply at once. This work is of the greatest importance to the success of the National Defense program.

Grant Provides Continuance of Vital Child Study.—Continuation and extension of critical and comprehensive studies, already under way, on the mental and physical development of school children have been made possible for the Institute of Child Welfare of the University of California through a grant of \$61,700 by the General Education Board.

Under the grant a research center will be opened by the Institute on September 1 at 2241 College Avenue, in Berkeley, supplementing the present offices of the Institute on Bancroft Way. This additional building will contain library facilities for the use of students in the field of child development and statistical and research offices for members of the staff, graduate students, and other members of the university faculty who desire to use the Institute's facilities.

One of the specific studies to be pursued under the grant deals with the analysis of physical changes as shown by growth in height and changes in body proportions, physiological maturing as revealed by measurements of x-rays of the bones and assessments of physical ability and efficiency based on various functional tests and laboratory records of physiological changes during exercise. These various indices of the development of body structure and functions are being considered with reference to collateral changes which may occur in psychological characteristics, such as interests, attitudes, emotional traits, and other aspects of personality.

The grant will be administered under the direction of Dr. Harold Ellis Jones, Director of the Institute, and will cover a four-year program. In discussing the program, Doctor Jones said:

"The majority of previous studies in this field have dealt with specific aspects of development and have been limited to problems and methods which lie within the individual fields of psychology, physiology, physical growth, etc. There remains, however, an important task of investigating interrelationships involving these various fields."

Refresher Course: University of California Medical School.—The University of California Medical School is making plans for an intensive refresher course on "The Clinical Aspects of Dermatology." This will be held in Toland Hall, University of California Hospital, San Francisco, from January 6 to 8, 1941, inclusive. The program, which is now being prepared, will cover various common skin conditions, including tumors. Surgical aspects of dermatological problems will be considered and there will be lectures on infectious diseases.

The Dean's Office, University of California Medical School, Medical Center, San Francisco, upon request will be glad to supply any physician with more complete information about the course.

Foundation Gives Cancer Research New Impetus.—Cancer research on the campus of the University of California has been given new impetus by the award of three Finney-Howell Foundation fellowships to members of the staff of the Radiation Laboratory. One of the three fellowships, that held by Dr. Paul C. Aebersold, research fellow in roentgenology, has come to him for the past three years. The other two, to Margaret N. Lewis, research fellow, and to Dr. Alfred G. Marshak, research associate in the Radiation Laboratory, come to the University for the first time this year. As far as is known, California is the only university to hold three of these fellowships at one time.

The Foundation was established through the will of Dr. George Walker, noted gynecologist at Johns Hopkins University, and named in honor of two of his associates, Dr. J. M. T. Finney, gastric surgeon, and Dr. William Henry Howell, physiologist. The amount provided was in the neighborhood of \$300,000, and it was stipulated that the total amount must be expended and the Foundation liquidated in ten years. This was done to accelerate the research activities under the Foundation and to achieve helpful conclusions in the shortest possible time. While none of the three doctors identified with the inauguration of the Foundation specialized in cancer work, they realized the necessity of intensive research in cancer cause and therapy.

Pacific Association of Railway Surgeons.—The thirty-eighth annual convention was held at Reno on September 20 and 21. The program, which was held in the State Building, follows:

Friday, September 20

Presidential Address, "What it has Meant to Me to be a Railroad Surgeon," by William Louis Weber, M. D., Los Angeles.

"Antiseptics and Chemotherapy," by Chauncey D. Leake, Ph. D., San Francisco.

Round Table: "Lesions Above the Diaphragm," by Doctors Robert A. Peers, Chairman, Colfax; William B. Faulkner, Jr., San Francisco; Bernard Kaufman, San Francisco; William L. Rogers, San Francisco; and Hans E. Schiffbauer, Los Angeles.

Address: "The Psychology of the Claims Adjuster," by Mr. Samuel A. Bishop, Los Angeles.

Saturday, September 21

Address: "The Organization of a Medical Department in War," by Lieutenant-Colonel Norman T. Kirk, U. S. A., M. C., San Francisco.

Round Table: "Lesions Below the Diaphragm," by Doctors Alson R. Kilgore, Chairman, San Francisco; Emmet Allen, San Francisco; Vernon Cantlan, Reno; and Colin C. McRae, San Francisco.

Symposium on Shock:

Chemical Aspects by Dr. T. Eric Reynolds, Oakland.
Clinical Aspects and Treatment, by Dr. Clayton Lyon, San Francisco.

Incidence of Syphilis.—Under existing preventive and control measures, at least one of every ten adults living in Washington, D. C., will acquire syphilis some time in life, the United States Public Health Service reported recently after a survey of venereal disease cases under treatment in the nation's capital. . . .

From an economic point of view, the study reveals that the prevalence rate for venereal disease among Washingtonians earning less than \$1,000 per year is 34.6 per one thousand persons. For persons receiving \$1,000 to \$2,999, the rate drops to 6.4 per one thousand persons. Persons with incomes over \$3,000 have a rate of 4.7 per one thousand.

"Only one person in five of those who seek treatment for syphilis does so when the disease is in the early stages," the report emphasizes. "Every infected person who neglects treatment during the first year of the disease represents a potential new case of syphilis. The preponderance of cases in the later stages emphasizes the need for more effective epidemiologic practices. Case-finding is an expensive, time-consuming, arduous task, but it returns big dividends in terms of syphilis control."

"Pay-Your-Doctor Week."—"Pay-Your-Doctor Week," inaugurated two years ago by the California Bank in Los Angeles on a purely local basis will be observed this year from October 27 to November 2 in scores of cities throughout the country, with banks in the various communities sponsoring the movement.

Recognizing the fairly widespread tendency to regard doctor bills as obligations that can wait indefinitely or at least until all other bills have been paid, "Pay-Your-Doctor Week" is proclaimed in order to call attention to the plight of many doctors who, to their great inconvenience, are on call twenty-four hours of every day but who are often paid at the convenience of their patients.

Because "Pay-Your-Doctor Week" was originated by a bank without the assistance of the medical profession, no question of ethics is involved and the movement has been hailed with favor by members of the medical fraternity everywhere.

Banks who sponsor "Pay-Your-Doctor Week" in various cities throughout the country publicize the idea widely, using newspaper advertisements, billboards, car cards and the like, to call attention to the occasion and to the fact that banks have on hand funds to lend for the excellent purpose of paying doctor bills.

Health Held to Be as Important as History.—A proposal that health be placed on an equal rating with history or with any other formal subject in the curricula of the colleges and secondary schools, was set before a special conference on health education on the campus of the University of California. The conference was conducted by the university's School of Education under the sponsorship of the California State Department of Public Health. The conference leader was Dr. Mayhew Derryberry, senior health education analyst of the United States Public Health Service.

The discussion of the introduction of health instruction into other courses brought general agreement among the delegates that health study should permeate every possible phase of instruction. The final consensus was that at the junior high school, high school and college level, health instruction should be included in regular studies and special health courses were also desirable.

The objectives of the program prepared by the conference were to make it possible for every child to develop his inheritance of health, whatever it might be, physically, mentally, emotionally and socially, and to provide in the school curriculum for an adequate community health program.

Central American Doctors to Study at Medical School.—A plan which will enable young Central American physicians to take special training at the University of California Medical School was announced recently by President Robert Gordon Sproul, who is now acting as dean.

According to the terms of the plans, two young graduate physicians who can speak English will be sent every year by each of the Central American nations for two years' special study in preclinical and clinical subjects, under the guidance of an advisory committee.

Central American countries which will send representatives include Costa Rica, Salvador, Guatemala, Honduras, and Nicaragua.

Annual Symposium on Heart Disease.—The San Francisco Heart Committee of the San Francisco County Medical Society will hold its eleventh annual Postgraduate Symposium on Heart Disease on November 26-28, 1940.

Clinics on the various aspects of heart disease will be conducted at the University of California Hospital, Stanford University Hospital, and San Francisco Hospital. The course will include demonstrations of patients presenting problems in the various types of heart disease, discussion and evaluation of specific diagnostic procedures and therapy and differential diagnosis, and treatment. There will be ward rounds, and special classes in x-ray, fluoroscopy, and electrocardiography.

On November 27, in collaboration with the symposium, a morning and an afternoon session will be held at Mount Zion Hospital for the purpose of discussing the public health aspects of heart disease. There is no registration fee in connection with the public health sessions. All who wish to do so are invited to be present.

On the evening of November 27, the annual dinner meeting will be held at the Western Women's Club. A program of unusual interest is being prepared for this annual occasion.

The San Francisco Heart Committee, of which Dr. William W. Newman is chairman, is affiliated with the California Heart Association and the American Heart Association.

Dr. Richard D. Friedlander is chairman of the Program Committee, which is composed of Doctors Francis L. Chamberlain, Gordon E. Hein, William J. Kerr, J. K. Lewis, Charles A. Noble, Jr., J. Marion Read, and Harold H. Rosenblum.

A program with full details regarding the symposium session, registration fees, and other particulars will be mailed on request. Communications should be sent to: Mary B. Olney, M.D., Secretary, San Francisco Heart Committee, 604 Mission Street, Room 802, San Francisco.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

"Life" and Osteopathy*

In *Life*, which is a picture magazine, for August 19 appears an article entitled "Osteopathy's 'Cure-by-Manipulation' Is Attacked by Regular Physicians." Here a small amount of text is supplemented by a number of photographs, evidently made in or supplied through the osteopathic shrine at Kirksville, Mo., known as the Kirksville College of Osteopathy and Surgery. In the very brief text which accompanies the pictures appear a number of misstatements of fact which, it is not too confidently expected, the magazine may correct. Many of these misrepresentations have been repeatedly exposed in *The Journal*. In the second paragraph of the article, for example, appears this statement:

"In thirty-three states qualified doctors of osteopathy are permitted to practice on equal or almost equal footing with doctors of medicine. Osteopaths can and do deliver

babies, perform surgery, prescribe drugs and take full charge of patients."

The facts are that in only four states (Colorado, Massachusetts, New Hampshire and Texas) for certain, and perhaps in a fifth (Kentucky), may osteopaths now legally prescribe or dispense drugs without restriction. This is true in the first four states mentioned because in those states osteopathic applicants, if licensed at all must meet the requirements exacted of applicants to practice medicine generally. To this list may be added, after November 1, 1941, a sixth state (New Jersey), where osteopaths licensed after that date will be subject to the same requirements as nonsectarian applicants and will receive an unlimited license to practice medicine.

Experience has shown that few osteopaths indeed are able to meet the requirements exacted of applicants to practice medicine generally.

In twelve states, osteopaths are given limited right to use certain drugs, the drugs concerned varying in the various states.

In eight states, osteopathic licentiates generally may not use drugs, but the laws contain provisions whereby osteopaths may, under certain conditions, obtain licenses by virtue of which they may use drugs, the law of one of these states even then permitting the use only of a very limited number of drugs.

In eight states, osteopaths are specifically denied the right to use drugs.

In nine states, osteopaths secure licenses only to practice osteopathy, without defining the scope of the practice permitted, but no court has ever held that the right to practice osteopathy includes the right to use drugs.

In seven states, osteopaths are licensed to practice osteopathy as taught in recognized schools of osteopathy which, in effect, denies them the use of drugs, and the Supreme Court of Kansas has recently held that the right to practice osteopathy as taught and practiced in recognized schools of osteopathy confers no right on osteopaths to practice operative surgery or to use remedial drugs.

To summarize:

In twenty-four states, osteopaths legally cannot, under any circumstances, use drugs. In eight states by far the greatest number of osteopaths cannot use drugs, but it is possible for candidates possessing stated qualifications to obtain that right. In twelve states osteopaths may utilize stated drugs to a limited extent. Only in five states, probably, may osteopaths use drugs without restriction. Obviously, then, from the standpoint of the right to use drugs, which an osteopath must possess if he is "to practice on equal or almost equal footing with doctors of medicine," the article in *Life* is, to put it charitably, indulging in gross exaggeration, when it states, "In thirty-three states, qualified doctors of osteopathy are permitted to practice on equal or almost equal footing with doctors of medicine."

* * *

War Time Casualties

In all wars more soldiers have always died of disease than from violence. In the last World War a third more fell before the microbe than perished at the cannon. The casualty list showed 2,215 officers dead in battle, 2,605 in bed; and among the troops the ratio was 48,295 against 65,519.

It will not be permitted to happen again here among the guardsmen and draftees who are being called up for training, at least partly as a result of the efforts of an unknown freshman Congressman, Representative Albert F. Austin, a Connecticut Republican. A physician, former health officer, regimental surgeon of the Wolverine Division in the World War, he tucked an amendment into the draft bill which is causing Mr. Roosevelt and the general staff plenty of headaches but may save the trainees from them.

As originally adopted, the Austin amendment would prevent the drafting of anyone for whom there was inadequate housing, light, heat, sewage and hospital facilities approved by the United States Public Health Service. The Administration succeeded in changing the final form of the law so that the Secretaries of War and Navy are personally responsible instead of the Public Health Service.

All Congress has such confidence in the efficiency of the Army and Navy leadership as to be willing to trust it where it would not trust the political management of some other Governmental departments. Confirmation that their trust is justified lies in the fact that the first summons for draftees is being delayed until the Army housing project can be started. Latest inside information is that 400,000 will be called before January 1, and the call will begin about November 15—after the elections are over.

Houses will be provided for all stationed above the latitude of Washington. Tent camps will be built here and farther south. The Army considers tents superiorly healthy where the climate permits because men do not live under such crowded conditions as in barracks.—Paul Mallon in San Francisco *Examiner*, September 25.

* Excerpt from *Journal A. M. A.*, August 31, 1940, page 787.

Health Service System of San Francisco*

Managers of the Health Service System for municipal employees and the employees of the Board of Education of San Francisco have issued a first annual report covering fifteen months of operation of a plan covering 15,000 persons. The information which follows is taken from that report.

The membership was made up of 9,809 employees, 3,124 adult dependents and 1,817 minor dependents. This was an average monthly membership during a period when there was a steady increase in members. The premium for each employee and adult dependent was \$2.50 a month. Minor dependents under 18 years of age were charged \$1.50 a month, and each additional minor dependent \$1.00 a month.

The percentage distribution of expenditures given in the first table was made from the total of the combined funds.

Of the total of \$355,232.77 disbursed for medical care, approximately 68 per cent went for doctor service, 23 per cent for hospitalization and 9 per cent for x-ray, clinical laboratory examinations, ambulance and physical therapy.

Nearly a quarter of a million dollars was paid to doctors during the first year for the treatment of 10,696 individuals. This is 73 per cent of the entire membership. Sixty-seven

Percentage Distribution of Expenditures

Doctors	57.9
Hospitals	19.5
X-ray laboratories	3.8
Clinical laboratories	2.2
Ambulance	0.4
Physical therapy	1.3
Medical overhead	5.3
Nonmedical overhead	7.9
Equipment and alterations	0.5
Unexpended balance	1.2
	100.0

per cent of the employees had the service of a doctor by the end of September, 1939, and that percentage went up to 75 by the end of the calendar year. It was recognized that there was considerable abuse of the system. Nine hundred and eighty-six local doctors and ninety-four out-of-town doctors participated in the Health Service.

The chief complaint of the doctors has been that the monthly value of the unit of service was too low.

Thirteen hospitals received a total of \$81,422.80 for the hospitalization of 1,500 persons during the twelve months ended September 30, 1939. The average cost per case was \$54.28.

Payment to the hospitals is made at the flat rate of \$7.20 a day, regardless of the amount of service used. In some

Payment to Doctors and Value of Unit by Months (October, 1938-September, 1939)

Month and Year	Paid to Doctors	Value of Unit
October, 1938	\$ 13,452.00	\$1.00
November, 1938	17,603.50	1.00
December, 1938	38,063.00	1.00
January, 1939	17,940.75	0.50
February, 1939	18,874.87	0.65
March, 1939	17,801.04	0.50
April, 1939	18,948.17	0.54
May, 1939	19,543.34	0.57
June, 1939	19,630.78	0.57
July, 1939	19,174.62	0.66
August, 1939	20,273.08	0.65
September, 1939	20,451.42	0.67
Total	\$241,756.57	\$0.66

so-called "come and go" cases, in which the patient is confined only part of the day, the full daily rate is not charged.

This entitles the patient to a ward bed, meals, general nursing care, floor supply of drugs and dressings, x-ray and clinical laboratory examinations, use of operating room, administration of anesthetic and various other services. A patient may select a private or semiprivate room by paying to the hospital the difference between the regular ward rate and the rate for any other room he may choose. Many patients chose the higher priced accommodations.

This year's experience has shown that the cost of providing hospital benefits was 46 cents per subscriber monthly, exclusive of overhead.

In November, 1939, several changes were made in the plan. The rate of contribution for all minor dependents

was raised to \$1.50 a month and the following changes in the service were adopted to affect dependents only:

1. Treatment was limited to one year for any one condition, illness or injury.

2. The rate for minor dependents was increased to \$1.50 a month regardless of the number enrolled by the employee.

3. In the future all dependents must have a medical examination before being admitted to the System and any pathologic condition existing at that time will have to be corrected before the person is admitted; or the person may be admitted but the Health Service will not be responsible for the bills for treatment of that condition.

4. No minor dependent will be admitted until attaining the age of one year.

The number of office visits for either dependents or employees for which the Service will be responsible has been limited to five a month. This was a counter proposal to the one made by the doctors' committee that the patient be required to pay for the first two office visits and the first two home visits. Henceforth, all subscribers are to be restricted to the service of one doctor a month except with the consent of the medical director. This was to prevent patients from shopping around for the same condition. Refractors were also eliminated from the benefits beginning with November 13, 1939. The fee schedule was revised to permit the general practitioner to receive more remuneration for his services.

The administration costs were 13.2 per cent, and it is believed that this can be reduced in the future. Demands of osteopaths and chiropractors and practitioners of drugless therapy for a right to practice under the plan are in course of litigation.

The average cost per employee member monthly for medical services is \$1.87, adult dependents \$2.28, and for minor dependents \$2.05.

* * *

Officer Appointments in Reserve Restricted

No new appointments will be made in the Officers' Reserve Corps, with the exception of those in the Air Corps Reserve, Chaplains' Reserve, Medical Corps Reserve, Dental Corps Reserve and Veterinary Corps Reserve, according to Lieutenant General John L. DeWitt, commanding general of this area.

Maximum age limits for appointment are: Air Corps Reserve, 30; Chaplains' Reserve, 42, and the other reserves still open, 35.

Commissions in the Medical, Dental and Veterinary Corps Reserves are restricted to recent graduates of Class A schools who desire extended activity with the regular Army.—San Francisco Chronicle, September 25.

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Professional Men in Napa Meeting

An address on "Human Responsibilities" by Dr. Harry Wilson of Los Angeles, and talks by other prominent guests featured a meeting of more than one hundred doctors, dentists and lawyers and guests of the Napa County Medical Society here last night.

Dr. Harry Wilson, president of the California State Medical Association, flew here from southern California to be the main speaker at the meeting, conducted in the Plaza Hotel by Dr. R. C. Burkett, vice-president of the medical society, in the absence of President Dr. Frank McCreane of Calistoga. Program for the night was arranged by Dr. George Dawson, chairman of the legislative committee of the society group.

Speakers Heard

Speakers at the meeting included Dr. Charles A. Dukes of Oakland, Senator Frank Gordon and Superior Judge Percy S. King. Doctor Dukes, a member of the American Medical Association committee of ten on medical preparedness, described the work done at recent meetings in New York and Chicago, correlating the work of physicians throughout the nation with that of the surgeon general's offices.

Under the plan of medical preparedness, a chairman is named for each county to correlate county work with the State Council of Defense, to handle work and examinations of the draft. Dr. D. H. Murray of Napa is chairman for this county.

Senator Gordon spoke on matters of general legislative interest while Judge King addressed the professional men present showing the links between the work of doctors and lawyers. Ben Read of San Francisco, executive secretary of the Public Health League of California, addressed the meeting on legislation of interest to doctors and dentists.

Short Addresses

Short talks were heard from the following: Dr. George Kress, of San Francisco, secretary of the State Medical Association; Dr. John Green, of Vallejo, councillor of this district for the association; Doctor Madeley, of Vallejo; Dr.

* From the Journal A. M. A., August 17, 1940.

Fred Butler, director of the Sonoma State Home; Dr. Ruggles Cushman, former director at Mendocino State Hospital; Major A. H. McLeish of the Veterans' Home; Dr. Walter Rapaport, present director at Mendocino; Dr. Lowell Brown, president of the Napa-Solano Dental Society; Dr. Rudolph Toller, assistant superintendent of the Napa State Hospital; Dr. L. L. Stanley of San Quentin prison, and Dr. Fred Clark, of San Rafael, secretary of the Marin County Medical Society.—*Napa Register*, September 5, 1940.

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Medical Men Meet Saturday

Placer County Society to Be Hosts to Eighth Councilor District Medical Men at Tahoe Tavern This Week End

A postgraduate medical meeting will be held at the Tahoe Tavern this Saturday afternoon and evening and Sunday morning with the Placer County Medical Society acting as hosts to the members of the eighth councilor district which comprises all of the territory north of the Calaveras County line to the Oregon state line and east of the Sacramento. The district also includes Yolo, Glenn, Tehama, Colusa and Shasta counties.

The Woman's Auxillary of the Medical Society of the eighth district will also meet at the same time and place.

Dr. Frank McDonald, Sacramento, councilor of the eighth district, is chairman of the arrangements.

Medical lectures will be given by distinguished members of the medical staffs of the University of California and Stanford University.

Among other distinguished medical leaders who will attend will be Dr. Henry Rogers, of Petaluma, president-elect of the California Medical Association; Dr. George H. Kress, secretary of the state organization, and Dr. Charles A. Dukes, past president of the California Medical Association.

On Saturday evening a dinner dance will be held with Dr. Robert A. Peers of Colfax acting as toastmaster. The principal speaker at the dinner will be Ben S. Allen, former representative of the Associated Press in London and a close associate of former President Herbert Hoover. Mr. Allen will talk on war time censorship during the first world war.

Dr. William M. Miller of Auburn is president of the Placer County Medical Society, the host organization.—*Colfax Record*, August 23, 1940.

* * *

Utah Man Named Rail Surgeon President

Dr. R. S. Allison of Salt Lake City was automatically advanced to the presidency of the Pacific Association of Railway Surgeons at an executive session this afternoon as the thirty-eighth annual convention of the association ended its business meeting and prepared for a banquet and entertainment program at Lawton's Springs tonight and a barbecue at Calvada tomorrow afternoon.

Doctor Allison advanced to his position as head of the association from the first vice-presidency. Dr. Ralph M. Morrison, Portland, Ore., second vice-president, advanced to the post vacated by Doctor Allison.

Highlights of the scientific sessions which wound up this morning were discussions of diseases above the diaphragm and below the diaphragm at two round tables. Dr. Chauncey D. Leake of San Francisco spoke to the surgeons yesterday on the value of various antiseptics, and addressed the women of the convention on cosmetics at a 10:45 o'clock breakfast at the Riverside hotel this morning.

The development and organization of a medical department in war time was explained to the delegates and guests this morning by Col. Normann J. Kirk, United States Army medical corps of San Francisco.

Entertainment tonight at the banquet will include professional acts. Speaker at the banquet will be Judge Frank H. Norcross. The barbecue tomorrow afternoon at Calvada, Lake Tahoe, will end the convention.

Additional registrations were received this morning, and with delegates, wives, guests, exhibitors and members of the sponsoring Washoe County Medical Association, approximately two hundred are expected at the dinner tonight.—*Reno Evening Gazette*, September 21.

* * *

New U. C. Cyclotron Holds Key to Mystery of Cosmic Ray

It'll Be Built in Three Years

Dr. Lawrence Hopes for Bigger Successes

When Dr. Ernest Orlando Lawrence, the atom smasher, walks around the radiation laboratory on the University of California campus, something beats, insistently, in the back of his mind.

It is the vision of the most powerful atom smasher, scientifically known as the cyclotron, ever conceived in the mind of man.

It will look something like the Taj Mahal with the pinacles lopped off. It will dwarf the present 225-ton cyclo-

tron, now operating in a new building on the campus, by twenty times. Its huge electromagnet alone will weigh four million pounds. The gargantuan cyclotron will permit a frontal attack on a colossal scale against the nuclei of the atoms—so colossal, in fact, it will create 100 million electron volts.

Ready in Three Years

With this gigantic new cyclotron, which is just being started on the hill near the big "C" in back of the campus and will be finished three years hence, Doctor Lawrence hopes to penetrate the secrets of the mysterious cosmic rays by literally creating them in the laboratory.

With it Doctor Lawrence and his fellow worker, Dr. Donald Cooksey, hope to increase the production of practical atomic power and the transmutation of the elements never before dreamed.

Which may give you an insight into the remarkable possibilities of the man and his machine, the scientific aspect of the man whose work in atom smashing won him the 1939 Nobel Prize, the richest and most coveted award available to a physicist; the man whose work with atoms makes him a whirlwind force in the field of science.

What Lies Ahead?

What is the field of this giant cyclotron to end all cyclotrons which will be buried in the hillside a short hike in back of the big "C"?

As Doctor Lawrence puts it, your guess is as good as his.

Basic point of the attack with the new \$1,250,000 cyclotron will be to study the enormous binding energies which link protons and neutrons in atomic nuclei and thus hold matter together into a stable form which we recognize as a table, a piece of salt or any element or chemical compounds. . . .

To understand the nucleus of an atom, Doctor Cooksey suggests you think of a fly in a cathedral. The atom is the cathedral. And the nucleus—yes, it's that small—is the fly. By a process of ionization the fly is freed from the cathedral (atom). First, 200,000 volts of energy are shot into the chamber and the nuclei cross a space of several feet in only 20-millionths of a second. By alternating currents on the plate the volt energy is increased, the nuclear force grows greater and greater.

It acts like a child in a swing, Doctor Cooksey tells you. The electric field in synchronization gives the nuclei an added push. In short, with the same amount of energy applied at the right time the nuclear force becomes tremendous. The nuclei travel at a speed of something like 60,000 miles per second.

Unlimited Discoveries Seen

By the energetic bombardment of elements and substances with particles accelerated in a 2,000-ton cyclotron it is not exactly day-dreaming to expect the field of medical and physical science to reach points of great magnitude.

Now, are Doctor Lawrence and his fellow physicists around the University of California day-dreaming when they see almost unlimited discoveries in the world of science just three years away—when that gargantuan "plaything" atop Strawberry Hill starts pounding atoms as they've never been pounding before?—*San Francisco News*, September 11.

* * *

Medical Group to Aid Defense

Chicago (UP).—This country's defense preparations must include a medical program as well as appropriations for increased armed forces, according to the *Journal* of the American Medical Association.

To facilitate the medical profession's part in the defense program, the *Journal* said, a committee of medical preparedness has been created by the American Medical Association to cooperate with the Advisory Committee on National Defense, the Army and Navy Medical Corps and the Public Health Service.

The committee is composed of fifteen physicians practicing in various sections of the country and is headed by Dr. Irvin Abell, Louisville, Ky.

Its functions include:

1. Consideration of problems involved in supplying adequate medical personnel for military, naval and civilian needs under any contingency.
2. Provide for adequate personnel to handle physical examinations, particularly of men conscripted for the medical service, men assigned to vocational training and persons on relief.
3. To represent the association in conferences with the surgeon generals of the Army, Navy and Public Health Services, and with other governmental agencies.
4. To cooperate with state committees on medical preparedness.

5. To receive recommendations from state committees on physicians whose services are believed necessary for maintenance of civilian health and who should, in the opinion of the committees, be exempt from military service.

6. To assist in the verification of qualifications of physicians desired for service in the army or other national defense work.

The *Journal* of the American Medical Association in announcing the composition of the national committee, gives as its aim "to prepare our nation to meet any emergency."—*Riverside Enterprise*, September 9, 1940.

* * *

City Health Plan Revision Asked

Doctors Seek Adjustment in Scale of Fees by City Workers

A charter amendment granting San Francisco doctors a voice in the affairs of the Municipal Employees' Health Service System will be introduced in the Board of Supervisors today.

In behalf of the physicians and surgeons who provide medical care for the 15,000 city employees and dependents served by the System, the amendment is sponsored by the San Francisco County Medical Society.

The amendment would:

1. Grant doctors the right to petition for changes in the System's operation (within limits of the charter section creating the System) and require the Health Service Board to consider such petitions.

2. Empower the City Retirement Board to modify, as well as approve or disapprove as at present, Health Service Board action on contracts.

3. Bring the System's hospitalization arrangements into conformity with the State Insurance Code.

4. Provide for annual review of medical and surgical compensation schedules.

On November 5 Ballot

If submitted by the Board of Supervisors, the amendment will appear on the November 5 ballot.

Dr. William Reilly, President of the County Medical Society, said yesterday:

"By some chance, when the original charter amendment creating the Health Service System was drafted, the doctors whose services make the System possible were excluded from any participation in the System's affairs.

"During the two years the System has been operating, this situation has been the source of much friction and discontent. We doctors have had no right to initiate changes in methods or procedures whether we believed them in the interests of the patients or of the doctors themselves. We have had to assume the attitude of supplicants outside the doors of the Health Service Board and its medical director.

"Nearly nine months ago, for example, we requested, and the Retirement Board directed, the Health Service Board to discuss with us certain revisions of our fee schedule. These revisions concerned only the doctors, involving a redistribution of available medical funds among the doctors themselves. Not a cent of additional money was asked.

"Yet, after nine months, we are still seeking the Health Service Board's permission to effect this redistribution. Only the other day, the Board told us we had not followed the correct procedure to obtain this permission and that we must start over again.

"The value of our professional services to the System—we gave more than \$132,000 worth of free medical service to members of the System in the first year—the integrity and dignity of the medical profession entitle us to greater consideration than this.

Doctors Ask Voice

"The time has come to grant the doctors a definite, if small, voice in the affairs of the System itself, the right to initiate and press to a conclusion matters which the doctors believe will contribute to the System's efficient operation. That's what this charter amendment is designed to do.

"The Health Service Board has pending before the Board of Supervisors another charter amendment to make its employees subject to the Civil Service and retirement benefit provisions of the charter. We do not intend to oppose that amendment. We hope the Board will not oppose ours."—*San Francisco Examiner*, September 10.

* * *

Barristers Club Health Service Plan Meeting With Wide Endorsement

Registration Ends Soon

Urging all members of the Barristers Club to participate, Fred S. Farr, past president, yesterday announced the deadline for the California Physicians' Service had been extended to September 15.

More than forty-five members of the club have already applied for service facilities, Farr said. Forty per cent of the club's membership must sign before the service becomes available.

The plan, which costs \$2.50 per month, includes health, accident and hospitalization and has been endorsed by the California State Medical Association, Harry S. Young, President of the Bar Association, and other leading lawyers.—*San Francisco Recorder*, September 5, 1940.

* * *

Geiger Against Charter Change

Wouldn't Use Hospital for Paying Patients

Health Director J. C. Geiger today opposed a proposed charter amendment which would open San Francisco Hospital to paying patients after all indigent cases have been accommodated.

"San Francisco Hospital is financed by the taxpayers to care for the indigent poor and is the finest institution of its kind in the nation," he said. "Private hospitals are doing an excellent job of caring for those who are able to pay and should not be in competition with a tax-supported institution."—*San Francisco Call-Bulletin*, September 5.

* * *

Institutions Separated From Other Charities

Hospital, Sanatorium and Poor Farm to Be Under Director Responsible to County Board

Action to separate the three major county charity institutions from the Los Angeles County Department of Charities and place them under a director without the necessity of a County Charter amendment and still keep within the law, was taken yesterday by the Board of Supervisors.

The institutions to be affected are the Los Angeles County General Hospital with an annual budget of \$5,500,000; Olive View Sanatorium for the treatment of indigent tuberculosis cases with a yearly budget of \$1,650,000, and the County Poor Farm, known as Rancho Los Amigos, with a budget of \$1,550,000.

Answerable to Board

All three will be under the supervision of the County Superintendent of Charities, as required by law, who will be a director directly answerable to the Board of Supervisors.

The other activities of the Charities Department, with the institutions out, will be under the supervision of a County Director of Public Assistance, the new title to be created by a county ordinance to be adopted by the Board of Supervisors. These activities will include old-age pensions, child and blind aid, direct relief, etc.

Plan of Allen

The action of the supervisors was taken on the recommendation of County Manager Wayne R. Allen, who declared that the new arrangement would create a saving of at least \$50,000 annually for the taxpayers of the county. It can be done, too, he said, without the necessity of a vote on a charter amendment as the institutions will be under the County Superintendent of Charities as the law requires.

Supervisor Gordon L. McDonough's proposal of a charter amendment to place the General Hospital in a separate county government department was voted down, 4 to 1.

Other Recommendations

The move of the Board of Supervisors to divorce the institutions from the Charities Department follows, to some extent, the recent recommendation of the Health and Welfare Committee of the County Grand Jury, which suggested a commission of seven members be created to supervise them. . . .—*Los Angeles Times*, September 11.

LETTERS

Concerning a Series of Lectures to Lay Audiences.

During the past several years the central office of the California Medical Association has coöperated with the Young Women's Christian Association of San Francisco by securing speakers for a lecture series that is given once or twice yearly.

Excerpt from a letter follows:

(COPY)

San Francisco, September 7, 1940.

Dear Mrs. McFarland:

Referring to our previous correspondence concerning lectures to be given at the Y. W. C. A., I am sending this additional information concerning the topics suggested by you.

The guest speakers and the topics they will discuss are as follows:

September 19—"Understanding Yourself and Others," John Alden, M. D., San Francisco.

September 26—"Learning to Relax," Ernest Lion, M. D., San Francisco.

October 3—"Learning to Live with Propaganda," W. A. Oliver, M. D., San Francisco.

October 10—"Mobilizing Your Emotional Forces (Mental Hygiene in Daily Living)," Helen L. Starbuck, M. D., Stockton State Hospital, Stockton.

As I understand the plan, the talks are to be of about forty-five minutes' duration, with allowance of fifteen minutes for subsequent questions and discussions. . . .

If we can be of further service, kindly inform us.

Cordially yours,

GEORGE H. KRESS, M. D.,
Secretary.

Concerning Cards of Physicians in Newspapers.

(COPY)

BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

Sacramento, California,
August 16, 1940.

Subject: Yours of August 9, Re Newspaper Advertising.

Dear Doctor ———:

Pardon this belated answer to your query of August 9 as to whether "it is ethical for a physician to have a 'card' in the local papers, stating his hours and giving the address of his office."

In so far as is concerned the administrative work of the Board of Medical Examiners, there is no legal objection to a professional card in a newspaper relating the full name of the individual, suffix designating the degree which he holds, a statement as to the license issued to him, his address, office hours, and telephone number.

The question of ethics of such a card is within the province of the California Medical Association, George H. Kress, M. D., Secretary, 450 Sutter Street, San Francisco.

Awaiting your further pleasure, believe me

Very truly yours,

C. B. PINKHAM, M. D.,
Secretary-Treasurer.

c/o California Medical Association
George H. Kress, M. D., Secretary
450 Sutter Street
San Francisco, California

✓ ✓ ✓

San Francisco, August 20, 1940.

Dear Doctor ———:

Doctor Pinkham has sent to us a copy of his letter of August 16, on the subject of cards in local newspapers.

I am sending you a copy of the American Medical Association "Principles of Medical Ethics." On page 7, under Section 4, you will find a discussion of "advertising."

If we can be of any further service, kindly inform us.

Cordially yours,

GEORGE H. KRESS, M. D.,
Secretary.

Concerning Letter of Committee to Defend America.

EUGENE S. KILGORE, M. D.
490 Post Street

San Francisco, September 25, 1940.

To the Editor:—This is the letter of which I spoke—for publication in CALIFORNIA AND WESTERN MEDICINE.

It went to 140,000 United States physicians (those more than five years in practice). Thank you!

EUGENE KILGORE.

COMMITTEE TO DEFEND AMERICA BY AIDING THE ALLIES

(William Allen White, National Chairman)

8 West Fortieth Street, New York

Dear Colleague:

If you believe as we do—

That America has long been in this war in the rôle of sleeping prospective victim;

That the struggle for freedom abroad is a delaying action in our war;

That the British fleet is our present chief defense; and

That our wish to *Keep the War Out of America* can best be favored by *all possible* aid to Britain—"possible" meaning within the discretion of our state and service departments, freed from needlessly restrictive legislation.

If you believe these things, we invite your active participation in the work of this Committee. There is much to be done. *First*, enroll with your local branch or start one in your community—to keep in touch with rapidly changing events and needs for action. Write to the Committee for information.

Second, make your influence count. This means, at the moment, your own letters or telegrams to presidential candidates and congressmen; then letters from as many other persons as you can influence—brief letters, stressing the need for utmost possible aid. President Roosevelt should be addressed at the White House, Wendell Willkie at Republican Headquarters, New York, your senators at the U. S. Senate, and your representative at the House of Representatives.

And, *third*, will you send a contribution today to the Committee so that it may expand and intensify its work in arousing America from its rôle of sleeping prospective victim. With nation after nation it has been "too little and too late." Please make checks payable to Frederick C. McKee, Treasurer, and send to the Committee in the enclosed envelope.

Sincerely yours,

Subcommittee for Medicine

Emile Holman, M. D.	Warfield T. Longcope, M. D.
Eugene S. Kilgore, M. D.	J. H. Musser, M. D.
Roger I. Lee, M. D.	D. B. Phemister, M. D.
Ray Lyman Wilbur, M. D.	

P. S. Tentative plans are forming to circularize other professional and nonprofessional groups. Much will depend upon the response of the doctors. If you are in accord with our purpose, your immediate reply will be most helpful.—Committee.

Concerning "Hygeia": Special Subscription Price.

AMERICAN MEDICAL ASSOCIATION
535 North Dearborn Street, Chicago

Dear Doctor:

Imagine two million people reading *Hygeia* in their physicians' offices each month. A lot of people . . . a powerful influence for scientific medicine . . . but not imaginary!

Recently we made two independent surveys of physicians' waiting-rooms to see how many patients actually read *Hygeia*. The results were amazing! They showed a monthly readership of two million . . . and more than that, indicated that each person spent an average of fourteen minutes with *Hygeia*.

Certainly your office can and should share in this great influence. To show you how important we think it is for you to have *Hygeia* on hand, we make you this attractive offer . . . a subscription to *Hygeia* for the remainder of

this year and the whole of 1941 (16 issues) for only \$1.75. A saving of 50 per cent . . . 16 issues at the regular subscription rate would cost you \$3.50.

Hygeia is published by your own American Medical Association to help educate the layman to sane, healthful living. It is your ally in promoting scientific truths . . . in discouraging self-medication . . . in combating quackery . . . and in overcoming fears and superstition. What better way to give your patients the kind of helpful, authentic health information you want them to have?

All in all, Doctor, this is a rare bargain . . . your opportunity to get *Hygeia* at half-price . . . and at the same time get full advantage of its real influence among patients. Why not fill in the enclosed card and mail it with your check for \$1.75 today?

Very truly yours,

AMERICAN MEDICAL ASSOCIATION.
FRANK V. CARGILL,
*Circulation Manager, Hygeia, The
Health Magazine.*

Symptoms of War Gases: Their Treatment.

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

September 13, 1940.

To the Editor:—Enclosed you will find a chart showing the name and description and giving symptoms and treatment of war gases which has recently been incorporated in the book of instructions for use in the San Francisco Emergency Hospitals.

Central Office, 101 Grove Street.

Sincerely,

J. C. GEIGER, M. D.,
Director of Public Health.

Concerning a Letter Received by a California Physician.

The following letter was sent to the California Medical Association central office by a member of the Association:

(COPY)

Palo Alto, California, September 3, 1940.

To the Editor:—This letter that I am enclosing has aroused my curiosity. Frankly, I am not at all interested in answering it. I wondered, however, if you could give me any information about the company. It must be a remarkable piece of machinery that can give so much for nothing.

Thank you for any facts you can give me.

Sincerely,

“ “ “

The enclosure letter to which reference was made follows:

(COPY)

Letterhead of Company, etc.

Dear Dr. ———:

We have a very favorable report concerning your standing as a young, progressive doctor, and would like you to serve on the National Advisory Board of a nonprofit Disability Foundation being organized which will have headquarters in your part of the country.

Its purpose will be to pay incomes to individuals who become totally and permanently disabled through any cause, including any accident, any sickness, mental disorders, military service, or invasion. Such protection has been practically unobtainable from insurance companies for some years past.

The protection will be offered by the Foundation as a public service at the lowest possible cost. It is intended to

War Gases			
Name	Dispersed Form	Symptoms	Treatment
LACHRYMATORS (TEAR GASES)			
Acrolein Benzyl bromid Chloracetone Chloracetophenone	Gas Liquid Solid Solid	Profuse lachrymation; smarting and burning pain in eyes; blurred vision; photophobia.	Wash eyes with 1 per cent sodium bicarbonate solution. Dark glasses.
LUNG IRRITANTS			
Phosgene Chlorpicrin Palite Superpalite	Gas Liquid Liquid Liquid	Dizziness; grey cyanosis; marked cyanosis on exertion; coughing; marked dyspnea with bronchospasm; nausea and vomiting; early, intense pulmonary edema; acidosis; unconsciousness; collapse; death from asphyxia.	Bed rest; keep warm; oxygen inhalation; venesection. Morphine for restlessness. Sodium bicarbonate or physiologic salt solution intravenously. Caffeine, metrazol or digitan hypodermically, if necessary.
SENSORY IRRITANTS (SNEEZING OR VOMITING GAS)			
Diphenylchlorarsin	Dust or Toxic Smoke	Violent sneezing; coughing; nausea and vomiting; dyspnea; congestion or edema of lungs.	Irrigate nose and mouth with physiologic salt solution. Rest. Oxygen inhalation, if necessary.
SKIN IRRITANTS AND VESICANTS			
Dichlorethylsulfid (mustard gas) Chlorvinylchlorarsin (Lewissite)	Liquid Liquid	Dermatitis, itching, skin blisters; blindness; blurred vision; sneezing; retching and vomiting; dyspnea; incapacity; restlessness; cyanosis; collapse, shock. Death from asphyxia.	Wash eyes with physiologic salt solution containing 1 per cent sodium bicarbonate. Cleanse skin with bicarbonate solution, followed by application of bleaching powder paste, made with equal parts of water or Chloramin-T, 1 to 2 per cent; rinse skin. Apply benzocaine dusting powder to skin; tannin lotion, if necessary. Treat like burns. Later, treat for lung irritation (see above) and for collapse and shock, if necessary.

supplement, not compete with other types of protection offered by insurance companies and hospitalization plans.

If you will serve on the Advisory Board, the Foundation will give you the disability protection for yourself without charge. May I send you an outline of the plans to assist you in making a decision?

Yours very truly,
(Signed) : _____

Concerning Heart Pamphlets Obtainable from the American Heart Association.

Members who wish copies of the pamphlets referred to should write to California Medical Association, 450 Sutter, San Francisco. In due course, request will then be made for the number of pamphlets needed and these will be sent from the California Medical Association office. Letter follows:

(COPY)

August 27, 1940.

To the Editor:—The enclosed pamphlet, entitled *Standardization of Blood Pressure Readings*, is the result of careful study of the problem by Joint Committees appointed by the American Heart Association and the Cardiac Society of Great Britain and Ireland. Leading medical schools and all of the outstanding insurance companies are adopting this method as a standard procedure for teaching purposes and for keeping their records.

A copy of *Examination of the Heart* is also being sent you.

We are endeavoring to give these two pamphlets as wide distribution as possible and we hope that you will cooperate with us. If you will assume the transportation charges, we will gladly send you, with our compliments, as many of each of the pamphlets as you may wish.

AMERICAN HEART ASSOCIATION, INC.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Danger of Suit from Failure to Remove Broken Needle

There are a number of cases which have reached the Appellate Courts and others which have not gone beyond the trial court, in which a physician or surgeon has been charged with negligence for failure to remove parts of a needle shaft which has been broken while inserted in a patient's body. Physicians have at times permitted such foreign objects to remain in the body temporarily or permanently where either the condition of the patient would render a surgical operation at the time dangerous or where the needle is embedded in fatty tissue and likely to cause no harm. As to whether or not the facts in any particular situation will, as a matter of good professional practice, justify leaving the foreign object in the body will not be here discussed. The purpose of this article is merely to show what courts and juries have done in such situations.

In a Texas case decided in 1933, a surgeon had broken a needle while making a spinal injection in his patient's back. Removal of the needle would have required surgery, and the physician permitted the needle to remain, feeling that there was little chance that any pain or harm would come to the patient because of the needle's presence in the fatty tissue of the lumbar region. Three weeks later the patient returned, complaining of severe pains in the area and requesting that the surgeon remove the same free of charge. The surgeon refused to operate without the payment of an additional consideration, so the patient had it removed elsewhere. Suit was later brought against the physician for the cost of the removal operation and for

damages for pain and suffering. The jury found that the defendant had not been negligent in permitting the needle to remain in the area during the three weeks' period, but that when once notified that pain existed, was negligent in not removing the needle at that time and was liable for such pain as occurred thereafter. The liability of the defendant was based upon certain expert testimony to the effect that a broken needle in that region of the back should be removed as soon as possible to prevent its moving around, and that one left near the spine might possibly work its way into the spine and cause paralysis. In the particular instance the needle had worked its way nearly an inch from the point of original breakage.

A California case upon which a jury disagreed was based upon similar facts. A patient of very nervous disposition was given a lumbar injection during the course of which the needle broke off at the hilt and was left just under the surface of the skin. The defendant did not feel that it was necessary to remove the object at the time because of the patient's neurotic condition and for a period mentioned nothing to the plaintiff about the breakage. Later he told her of the breakage but stated that in that particular area there was much fatty tissue and little nerve fiber, and that, therefore, the object could remain indefinitely without pain to her. However, after the object had remained in the patient's back for some time, it was removed by another physician and suit was brought for pain and suffering. Expert testimony was presented on both sides; that of plaintiff tended to show that it is always more or less dangerous to leave a needle within the body, since it might work its way to a dangerous area—that regardless of the relatively few nerve centers in that area, there could have been some pain as a result of the foreign object—and, finally, that good practice requires the use of a needle with a protective shield so constituted that the breaking of the needle at the hilt will leave some portion exposed above the surface of the skin to assist removal. Defendant's experts testified that the type of needle used by the defendant was used in many hospitals and laboratories, that it was accepted by the medical profession as satisfactory; that there are circumstances under which it is not negligence to leave a needle within this area of the body. The jury was unable to agree upon the issue of negligence. Thus, although there was expert testimony tending to show that the defendant was not guilty of any negligence, nevertheless, the jury was not convinced of that fact.

Numerous other cases have dealt with the removal or failure to remove foreign objects from other parts of the body.

In one case, after a defendant physician had operated upon plaintiff, another doctor removed a needle from plaintiff's abdomen. The defendant did not deny performance of the operation or that the needle became embedded in plaintiff's side during the operation; however, he contended that plaintiff failed to establish by expert testimony any malpractice on his part. The jury rendered a verdict for the plaintiff on the theory that expert testimony was not necessary to prove negligence under such facts.

In a Washington case it was held that where a needle was broken during the performance of an operation, a verdict could be rendered where it was shown that the defendant had not made an examination of the needle before using the same.

The result of the decisions concerning broken needles makes it necessary to point out to the profession that there are instances in which the physician may be exercising his best judgment as to whether or not an operation should be immediately performed to remove a foreign substance, and yet be held liable for failure to make such removal. This is true because of the fact that the average jury, made up of laymen, is sometimes shocked by facts which to the medical profession cause no consternation.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 10, October, 1915

From Some Editorial Notes:

Records—Records—Records!—It is hard to make physicians see the importance of anything that looks like business. It is very difficult to make them see the commercial value to themselves of keeping careful and complete records of all their cases. The JOURNAL has repeatedly argued the paramount necessity for keeping such records owing to the increasing habit of the ordinary citizen to "sue the doctor." In fact, it is an open question whether or not the State Society should formulate some rule on this point which would withhold the benefits of its medical defense in suits brought against its members, unless the member can produce a complete and properly kept case history of his treatment of the former patient who brings the suit. . . .

1 1 1

The Safety of Patients.—More and more does it seem that the individual is asserting his inalienable right to seek medical opinion where and when he will; and while this right may not be denied, it is still not good for him. Conditions in connection with this phase of medical life, as in many others, are rapidly changing and while we must, as reasonable human beings, admit and accept such changes, it is well to remember the old order and, particularly, the reasons for the old order of things. Two brains are better than one. From consultation, from the rubbing together of thoughts, come enlightenment. One person suggests what detail fits into the thought of another. Taken separately, and without the interchange of thoughts and comments, the separate examination and opinion of several medical men is not a good thing for the safety of the patient. And that was the reason for the old ethical law or custom that one doctor would not see, examine or express an opinion about the patient of another doctor, save and except when they two were together. It was in the interest of the safety of the patient. Even now, with our changing conditions, it may be possible, sometimes, to make people see the wisdom of this course of procedure.

1 1 1

Doctors and Charity.—To say that the physicians of a community contribute more to charitable work than all the charitable organizations in that community combined, is to make a safely conservative statement of fact. Every physician knows that he will do a certain percentage of his work for which he will never receive any return whatever. All physicians are ready and willing at all times to advise on matters of public health, protection against threatened epidemics, and the like, or to give their actual services and time and effort for the public health of the people of the community in which they find themselves. It is ingrained in medical education and a fixed part of medical life. In view of these facts it has always seemed to the writer that for laymen to ask physicians to contribute in money toward the support of various charitable enterprises, was a sociologic blunder if not an impertinence. The conduct of public health movements, as the war upon tuberculosis, the study and prevention of cancer, and the like, are matters of primary interest to the community as such and their maintenance should be a community burden. If it is not assumed by the community, it should be assumed

(Continued in Front Advertising Section, Page 7)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

The results of the written examination held in Los Angeles on July 16-18, inclusive, show that approximately 110 graduates of medical schools, including some foreign graduates, passed the examination. The highest mark, 907/9 per cent, was made by Antonio Alberto Adames, M. D., graduate of the College of Medical Evangelists, June 9, 1940.

News

"Charges that the State Board of Medical Examiners was 'corrupt' and was 'as lawless a body as can be found in the State of California,' and an attack on the 'narrow-mindedness of the medical profession' were made today on the council floor by Councilman Arthur E. Briggs. It arose over a minor change in the ordinance regulating massage parlors and bath houses by including doctors, nurses, and students of medicine under the regulations. The State Medical Board, Briggs charges, operates 'in violation of the law,' and the Council would be 'playing down that Board's alley on this proposal.' He accused the medical board of being corrupt and of having 'no decency,' 'no conscience or charter (character).' At this point, he got into a personal discussion with Councilman Roy Hampton, who defended doctors generally, as well as the state board, and called Hampton 'muddle-headed.' . . . Members of the medical profession, Briggs said, belong to a period of the past, since in its capacity of the 'noble profession of the healing arts' it was still living in the thirteenth century, because of its 'narrow-minded attitude to others with whom it competes.' He took the occasion to apologize for his own profession, that of law, and said he was 'sorry' that his profession was in somewhat a similar position. . . ." (Hollywood Citizen News, August 15, 1940.)

"Motive behind the Government's move to cancel the citizenship of Dr. Herman Frederick Erben, San Francisco brain specialist and authority on tropical diseases, was revealed yesterday. The 43-year-old Vienna-born scientist himself admitted he is under investigation by the FBI and military intelligence service, on reports that he is in some way involved in Nazi espionage work. Doctor Erben said that Federal agents have been investigating his activities—particularly since he came back to the United States after serving as ship's surgeon on the vessel which acted as supply ship to the German pocket battleship *Graf Spee*, blown up in Montevideo harbor several months ago, after she had been riddled and chased into port by British men-of-war. . . . The Government charges that the Austrian surgeon obtained his naturalization under false pretenses, and that he falsified when he swore he had resided continuously here for five years preceding the naturalization. . . . Meantime he frankly discussed his work aboard the *Graf Spee's* supply ship—even to the startling assertion that he, as ship's surgeon, had been supplied with mysterious pellets, to be given out to members of the vessel's crew to swallow in the event they faced capture by the enemy. Doctor Erben, in making his revelations, also bared the fact that he has one son now serving in Hitler's armed

(Continued in Front Advertising Section, Page 26)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

PERFECTED Containers AND Equipment

...ANOTHER RESPONSIBILITY OF LEADERSHIP

The VACOLITER

A Container-Dispenser with
10 Distinctive Advantages

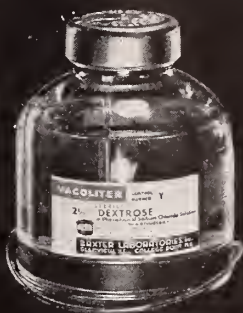
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Parenteral Solutions must be instantly available—so conveniently and dependably contained that delay or contamination can not occur. As a pioneer and leader in the field, Baxter has developed in the distinctive VACOLITER, with its exclusive visible index of vacuum, a container that renders hospital, physician and nurse a completely satisfactory service.

Baxter's Parenteral Dextrose and Saline Solutions are pure, uniform, stable—SAFE—and available everywhere in wide variety. To the hospital, they represent the utmost in true economy. Descriptive bulletin on request.

In the highly perfected TRANSFUSO-VAC* container and its accessories, Baxter has given the profession a widely accepted new technique of indirect BLOOD TRANSFUSION that bridges time and space with unbroken asepsis. With it one operator can perform the entire sequence—Drawing, Citrating, Transporting, Storing, Filtering and Infusion—with no break in asepsis and no waste of blood. On request, professional bulletin discussing the ease, certainty and economy of this new technique of blood transfusion.

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A complete closed tech-
nique for Blood Transfusion

Six sizes and solu-
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Solution is sterile
and pyrogen-free
2½% sodium citrate
in physiological
solution of sodium
chloride*

Container embodies
original, exclusive
features of Vacoliter,
with others of im-
portance

Second label pro-
vides for record of
contents in use



Vacuum provided
will draw desired
quantity of blood
and leave adequate
vacuum, visibly
proved by dimple in
diaphragm

Tamper-proof cap
indicates 250, 500 or
750 cc. use

X clearly identifies
site for insertion of
needle

Micrometer-fitted
Valve gives finger-tip
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(Continued from Front Advertising Section, Page 30)

as a "steamfitter" and operator of an "electronic appliance"), who on August 10, 1940, pleaded guilty in Modesto to violation of the Business and Professions Code, describes the contraption used by Glover as follows: "The home-made contraption used by him in giving treatments, supposedly an electrical short-wave machine, consisted of several large pieces of copper sheeting, copper wires and an electric box, was subsequently tested and examined by two San Francisco electrical manufacturing laboratories and found to be a fake. After testing the apparatus with an 'oscillograph' and finding no electric current present and no radio or electrical waves of any type being emitted, the box was opened and examined. It was found to contain only six dead plugs, in which the wires and copper sheeting running from said box to the patient were attached, one 180,000 ohms resistor and pilot light. The pilot light was wired so that when the box was connected with electricity, said light could be turned on. However, neither the resistor nor the six plugs were wired on a complete circuit and could neither receive nor give out any current or radio waves of any kind. Had any current gone through these plugs, he (Glover) would have undoubtedly electrocuted his patients since uninsulated copper was applied to their bodies in a manner that would make a complete contact through them. Several patients were interviewed and related they had paid this impostor considerable money for treatment of various diseases, including heart trouble, rheumatism, nervous conditions, etc. . . ." Barnum was right!

A very interesting sketch of Robert Faudree (mentioned in "News Items" of September, 1940), was published in *The Journal of the American Medical Association* on September 7, 1940, page 875, under the heading, "Robert Faudree—Medical Impostor—Charlatan Finds California Climate Unhealthy."

Health Officers of the State of California—By counties, August 1, 1940.

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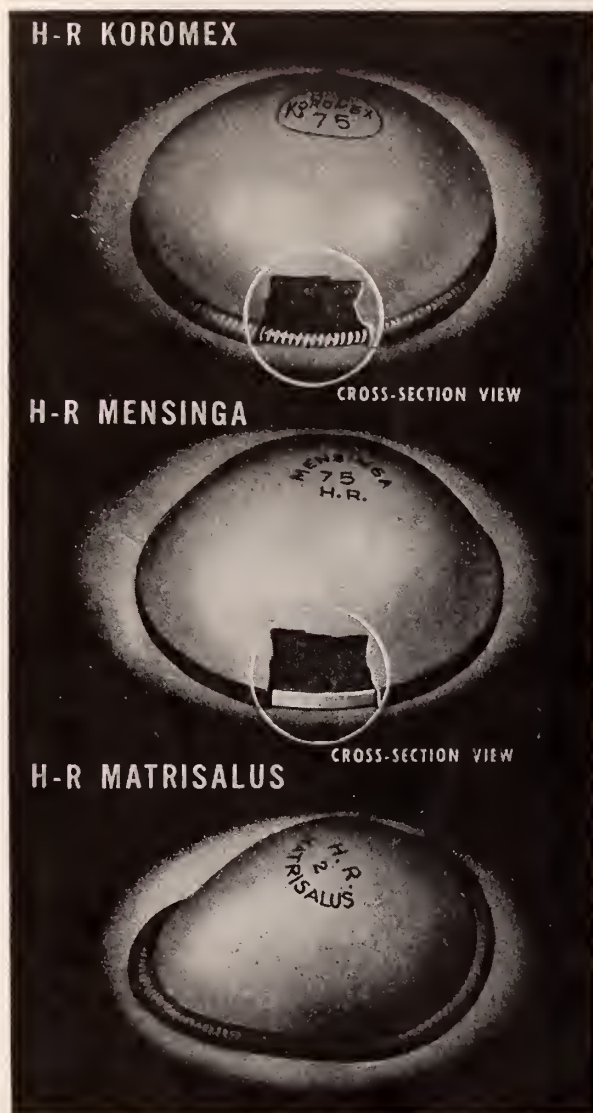
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OBESITY

(Continued from Text Page 162)

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With many forms of medication, a prolonged trial is necessary to determine whether or not the patient is being benefited. This is usually not the case with 'Benzedrine Sulfate Tablets'.

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Fresh and Stored Blood Transfusions.—"The incidence of all types of reactions was no greater from the transfusion of preserved blood than when fresh blood was employed, provided proper care was taken in storing and handling it," Dr. Elmer L. DeGowin, and Dr. Robert C. Hardin, Iowa City, report in *The Journal of the American Medical Association*. Their findings are based on a study of the results of 295 fresh blood and 2,128 stored blood transfusions.

A Method of Nutritional Protection During Senescence.—During senescence, many conditions are prevalent which tend to prevent the adequate utilization of a well-balanced diet. Degenerative processes, voluntary or required dietary restrictions and organic disease, especially if it occurs in the gastro-intestinal tract, all play an important rôle in interfering with proper digestion, absorption and assimilation. In this manner, they pave the way for nutritional deficiency states.

It is generally recognized that an adequate, energy-producing and nutritional protective diet is an essential requirement during old age. However, since an ample dietary regimen is usually not well tolerated by this type of individual, a fortified food drink was used as a supplement to their regular therapy. The purpose of this supplementary feeding was two-fold; first, to supply essential vitamin mineral elements, and secondarily, by using it as a flavoring agent to act as an incentive to these individuals to drink the required amounts of milk.

Thirty senile individuals having a variety of gastro-intestinal disturbances were given Cocomalt as a food drink. It was found that the product was well liked, well tolerated and did not cause any aggravation of their symptoms. In most instances, during one month of observation, there was an improvement in the red blood cell count and per cent hemoglobin, an increase in appetite and a moderate gain in weight. It was also found that the ability to tolerate milk was greatly enhanced by its use.

In conclusion, it may be said that the fortified food drink (Cocomalt) by itself may have limited therapeutic value. However, when used as a supplement to the regular necessary treatment, it is no doubt a valuable method in supplying essential vitamin-mineral elements in a pleasant form.—*Medical Record*, August 21, 1940.

Pure Luteinizing Hormone Isolated from Anterior Pituitary Gland.—The isolation in pure form of the luteinizing (interstitial cell-stimulating) hormone of the anterior lobe of the pituitary gland of swine was announced in the August 23 issue of *Science* by Doctors Shedlovsky and Rothen of the Rockefeller Institute for Medical Research, New York, and by Doctors Greep, Van Dyke and Chow of the Squibb Institute for Medical Research, New Brunswick, New Jersey. The achievement is specially noteworthy because the chemical nature of the endocrine principles of the anterior pituitary gland renders them difficult to isolate and analyze since they are proteins or complex polypeptides which are extraordinarily vulnerable to most types of ordinary chemical manipulation.

Proof of the purity of the luteinizing hormone was established by solubility studies in various buffer solutions, by obtaining electrophoretic patterns employing a Tiselius apparatus and by observations of the sedimentation rates in the ultra-centrifuge. From the data thus obtained and from the determination of the diffusion constant, the molecular weight of the pure luteinizing hormone was estimated to be approximately 90,000. Its isoelectric point was found to be at pH 7.45.

Chemical analysis of one specimen of pure hormone showed it to have the following composition: carbon, 49.37 per cent; hydrogen, 6.83 per cent; nitrogen, 14.93 per cent; ash, 0.93 per cent. . . .

The significance of this announcement to workers in endocrinology is that it contributes to the elimination of much of the preëxisting confusion with regard to the possible number and effects of the gonadotropic hormones which have been postulated by earlier investigators. . . .

Thus far it has not been possible to isolate large enough quantities of these pure hormones for clinical studies. This is obviously the next step as soon as satisfactory yields can be obtained. At any rate it seems to have been clearly demonstrated that two gonadotropic hormones can be isolated from the anterior pituitary gland. They are separate chemical entities and act on different structures within the primary sex gland (ovary or testis).

American Medical Association Preparedness Survey Fifty-Two Per cent Complete on September 6.—"On September 6 the Committee on Medical Preparedness (of the American Medical Association) had received 93,437 schedules from physicians throughout the United States and its outlying territories. This number represents 52 per cent of the 179,796 schedules which were mailed to physicians in July." *The Journal of the Association* reports in its Medical Preparedness Section.

"The response of physicians in different states showed a wide variation, from 83.2 per cent in Nebraska and 85.8 per cent in the Canal Zone to 38.5 per cent in New Mexico and 0.08 per cent in the Philippine Islands. Thirty-eight states showed more than 50 per cent of questionnaires returned.

"Now that the vacation season is nearing its close, some physicians may be expected to return the schedules which have been awaiting their return.

"Changes of address should be reported promptly to the Directory Department of the American Medical Association so that the Committee on Medical Preparedness can supply schedules to physicians who could not be reached on the first mailing.

"The first 50 per cent of returns represent a prompt and willing response from the physicians in all parts of the nation. It is earnestly hoped that the second 50 per cent will respond without delay."

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European War Blockade Is Lessening Receipts of Medical Literature.—The toll of the European war and blockade on medical literature being received from abroad is outlined by *The Journal of the American Medical Association*.

"Gradually since the end of May there has been a diminution in the receipt of medical publications coming from abroad to the *Quarterly Cumulative Index Medicus* and to the Library of the American Medical Association," *The Journal* reports. "The Library has been receiving in the past about 1,400 different periodicals. The most recent shipment from Germany arrived on July 22, at which time, however, only two periodicals were received. On June 26, eight periodicals came, but the last large shipment arrived on May 27. Already, therefore, some of the German publications are more than three months in arrears.

"Some Austrian weekly publications which used to arrive every seven to ten days have not been received since early in June. Polish and Czechoslovakian journals have not been received for many months. Sixteen such publications have been dropped from the *Index* since the beginning of 1940. Within the last two months official notification has been received of the suspension of eleven French medical periodicals. From Italy the last weekly receipts were at the end of June and few Italian publications have come since that date. The publications from Great Britain for June and July are being received with perhaps a very slight delay. Some publications dated July 1940 arrived in Chicago as late as August 17.

"The effects of the difficulty in the receipt of foreign periodicals are reflected in the current medical literature department of *The Journal*, from which no doubt readers have noticed the absence of some of the foreign publications which used to be listed and abstracted regularly. The *Quarterly Cumulative Index Medicus* will, likewise, show some diminution in size in the next issue. In the issue for January to March 1940, 8,160 articles were indexed from the foreign literature. In the issue for April to June 1940, 7,590 articles were indexed—a decline of 570 articles. The period July to September will be closed shortly; up to August 19, however, only 3,415 articles have been listed—a decline of more than 50 per cent in the material available.

"No doubt some of the decline in the foreign medical literature is due to difficulties concerned with the securing of paper and printing supplies and with the fact that many men are engaged in military activities. Unquestionably, also the blockade on shipping has prevented the transmission to the United States of some of the periodicals that are being published."

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Declares Hardening of the Arteries Biggest Future Medical Problem.—Arteriosclerosis, the hardening of the arteries which threatens all persons over fifty years old, is the vastest of all medical problems of the future as well as the most neglected, Dr. Irving S. Wright, New York, declares in *The Journal of the American Medical Association*.

With the average length of life prolonged to over sixty years, he points out, such a disease condition becomes of increasing importance. There are definite degenerative changes present somewhere in the arterial trees of practically all individuals over the age of fifty, thus making possible the onset of arteriosclerosis. "Of the population over fifty years of age," Doctor Wright says, "60 per cent (fifteen million) will die of some cardiovascular-renal syndrome (set of symptoms referable to the heart, blood vessels and kidneys), whereas only 9 per cent will die of cancer. A very large but as yet undetermined portion of that 60 per cent will die as a result of degenerative changes of the arteries, with the cardiac (heart), renal (kidney) or other syndromes merely the results of secondary ischemia (local and temporary deficiency of blood) or hemorrhage.

"As these syndromes frequently produce prolonged and painful disability before death, a change in philosophical approach might well be considered. Perhaps the mere prolongation of life should no longer be sought as the highest goal, but rather longevity only to such a degree as it is compatible with happiness and a full life free from pain and invalidism.

"The medical schools for the most part give woefully inadequate training in the study and care of arteriosclerosis. Too frequently the practicing physician fails to recognize its manifestations until gangrene has occurred. The public cares little for what it considers the vagaries of old age, although all who achieve old age are liable to them. Too few research workers have engaged in its study, to a large extent because of lack of endowment. Truly, it has been a neglected field in proportion to its importance."

Advises Studying Effect of Posture on High Blood Pressure.—Patients with high blood pressure should be studied with regard to the effect of posture on the hypertension and those in whom the pressure falls markedly when confined strictly to the recumbent posture should have their urinary tracts studied by x-ray, and if nephropsis (downward displacement of the kidney) is found some supportive measure for the latter should be instituted, Dr. William S. McCann, Rochester, New York, declares in *The Journal of the American Medical Association* in a paper prepared in collaboration with Dr. Monroe J. Romansky, also of Rochester.

The author says that such a study of the effect of posture on blood pressure should be made by comparing the pressure when standing upright with that found when lying flat.

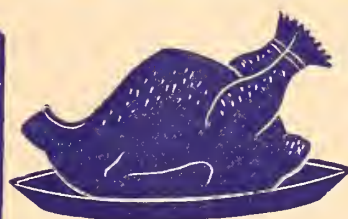
By supporting the kidneys by such measures as corseting, the blood pressure may be lowered and stabilized and many of the symptoms which accompany the hypertension may thus be relieved. It is pointed out, however, that "nephropsis does not always result in hypertension."

The individual physician must protect the families in his care, and through them the community, by urging physical examination of domestic employees. Repeated emphasis on the necessity of this should result in the earlier diagnosis of tuberculosis and in the prevention of exposure to infants and children from this source of infection. An annual health certificate declaring freedom from syphilis, gonorrhea, and tuberculosis should be the requisite for the position of nursemaid.—David V. Shard, M.D., *Jou. Lancet*, June, 1940.

A stylized illustration of a plate of food. The plate is oval-shaped and contains several items: a large, leafy vegetable (possibly lettuce or spinach) on the right, a smaller leafy vegetable on the left, and a central portion of food that looks like a sandwich or a stack of food. A fork is positioned at the top left of the plate, and a knife is positioned at the bottom right. The entire illustration is in a simple, graphic style with black outlines and some grey shading.

A stylized illustration of three cakes. Two are square cakes with white frosting and dark sprinkles, one slightly behind the other. To the right is a small round cake with white frosting and dark sprinkles.

A stylized illustration of a blue fish, possibly a cod or similar species, shown in profile facing right. The fish has a white outline, a white eye, and white markings on its body representing scales or fins. It is positioned above the text 'FISH' in the 'FISH' column of the word search grid.



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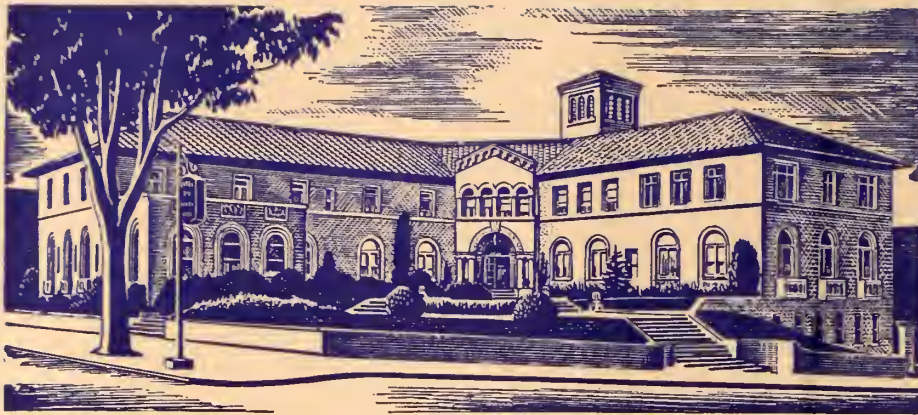
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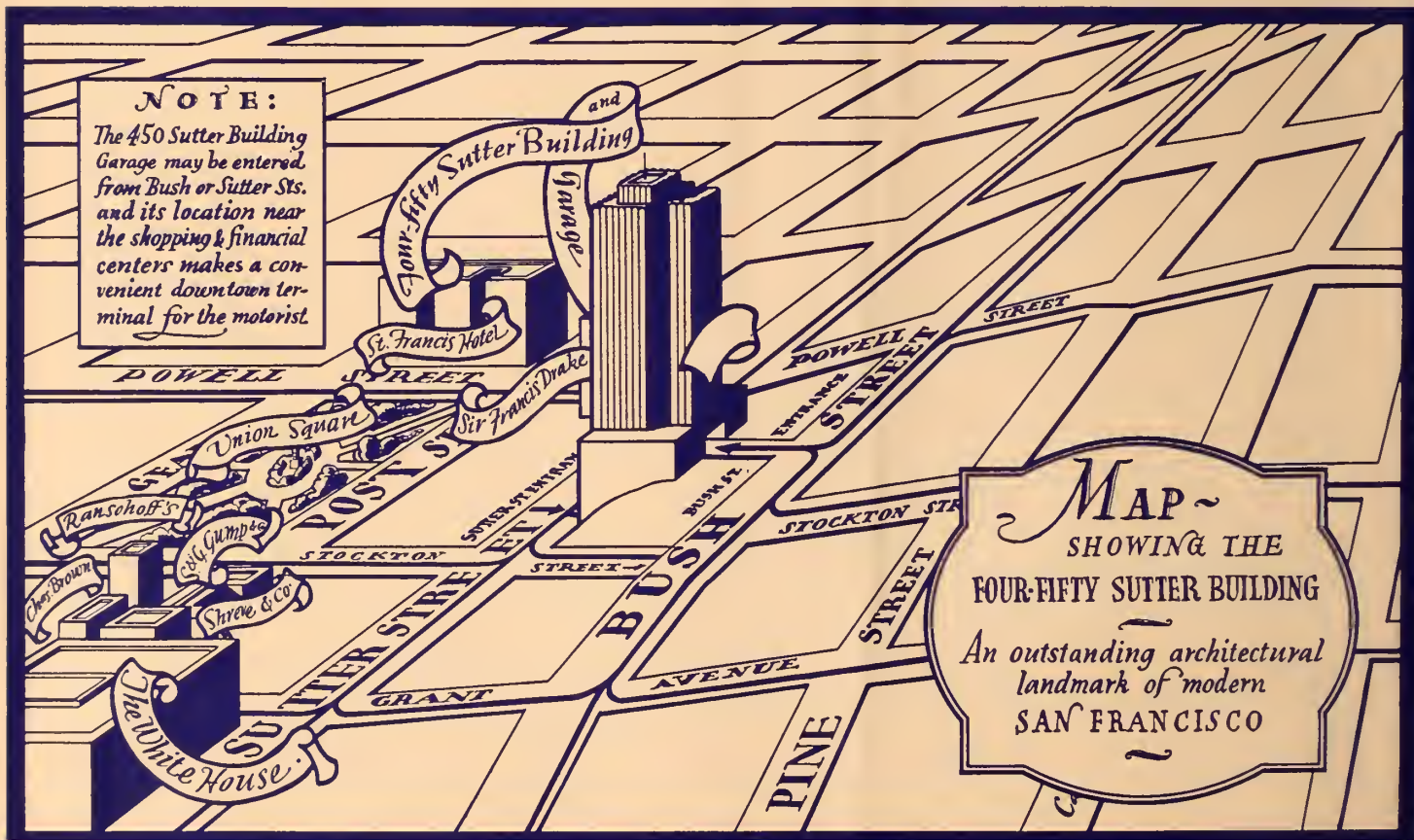
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"The mine run of these urinary tract injuries," he states, "are quite symptomless and obscure on admission. Indeed, so obvious and commanding are the symptoms of the other accompanying injuries and so silent are those of the kidney or bladder that important hours are often lost unless the prompt discovery of kidney or bladder injuries is assured through the routine inspection of the urine to note the presence or absence of blood in all accident cases at the time of admittance."

Without such a routine, followed by x-rays, which define the exact injury if blood is present and which suggest proper treatment, Doctor Sargent maintains, "the patient with a fractured pelvis may go many hours before her ruptured bladder is discovered or the man unconscious from skull fracture even bleed to death from an unsuspected kidney injury."

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HOSPITALS AND SANATORIUMS

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ALEXANDER SANITARIUM Nervous and Mental Diseases Belmont, California	COMPTON SANATORIUM AND LAS CAMPANAS HOSPITAL Neuropsychiatric and General Compton, California	PARK SANITARIUM Mental and Nervous Alcoholic and Drug Addictions 1500 Page Street, San Francisco, California
ALUM ROCK SANATORIUM For Treatment of Diseases of the Chest San Jose, California	FRENCH HOSPITAL General Hospital Geary at Fifth Avenue, San Francisco	POTTENGER SANATORIUM AND CLINIC For the Treatment of Tuberculosis Monrovia, California
BUTLER MANOR REST HOME Convalescent P. O. Box 32, Los Altos	GREENS' EYE HOSPITAL Consultation, Diagnosis and Treatment of Diseases of the Eye Bush and Octavia Streets, San Francisco	SAINT FRANCIS HOSPITAL Limited General Hospital Bush and Hyde Streets, San Francisco
CALIFORNIA SANITARIUM For Treatment of Tuberculosis Belmont, California	LARKSPUR CONVALESCENT AND REST HOME For general cases, excluding psychoses 234 Hawthorne Ave., Larkspur	ST. LUKE'S HOSPITAL Limited General Hospital 27th and Valencia Streets, San Francisco
CANYON SANATORIUM For Treatment of Tuberculosis Redwood City, California	LAS ENCINAS SANITARIUM Nervous and General Diseases Las Encinas, Pasadena, California	ST. MARY'S HOSPITAL General Hospital 2200 Hayes Street, San Francisco
COLFAX SCHOOL FOR THE TUBERCULOUS For the Treatment of Tuberculosis Colfax, California	LIVERMORE SANITARIUM Nervous and General Diseases Livermore, California	TWIN PINES Convalescent and Neuropsychiatric Belmont, California

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American Medical Association's Method of Rating Visual Loss Legally Adopted by Ten States.—Ten states have legally adopted by statute the American Medical Association's method for computing visual disabilities in compensation cases, the Association's Committee on Visual Economics report in *The Journal* of the Association.

The method, evolved from a report which was approved by the Association's House of Delegates fourteen years ago, is now legally sanctioned by the U. S. Government and the following states: Kansas, Maine, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Washington, Wisconsin and West Virginia. "In many other states in which no method has received legal sanction," the report says, "this method is employed by labor commissions and by ophthalmologists (eye physicians)."

In an effort to bring about a greater uniformity in the administration of compensation laws for loss of visual acuity, the committee has made a complete review showing the variations in the compensation statutes and laws of all the states. It points out that twenty-five states have not yet legally adopted any method for rating permanent partial visual disability. Twenty-one states have adopted statutory schedules for such loss. One state, Mississippi, has no visual compensation law, and another, Arkansas, has recently passed a law which has not as yet been adopted by the electorate.

There is also wide variation in such factors as the number of weeks for which compensation is given for the loss of the use of one eye or for the loss of an eyeball, the percentage of average earnings which form the basis for compensation, and the visual factors used in computing loss.

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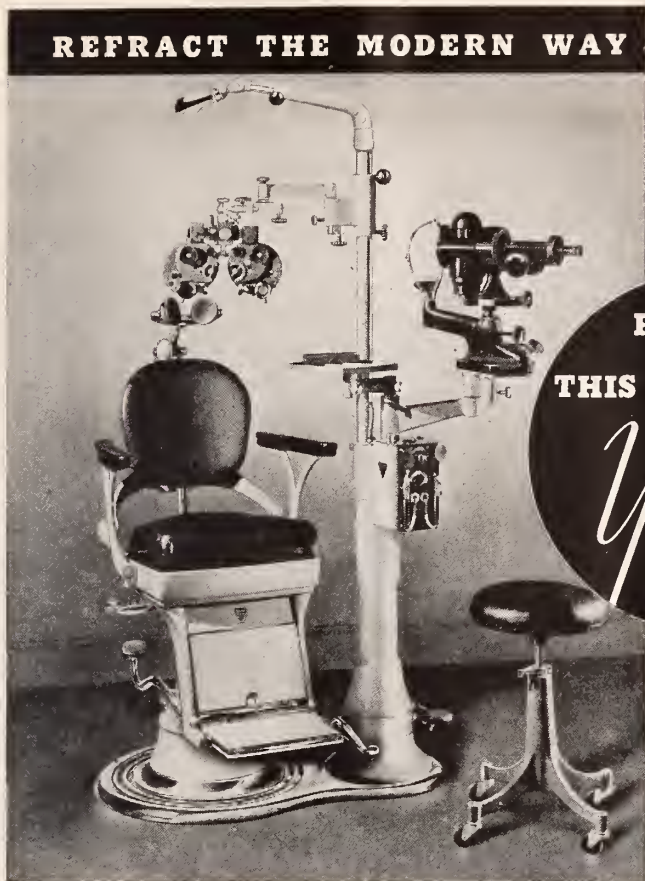
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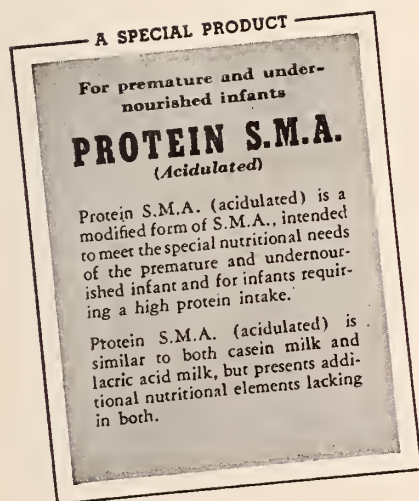
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BOOK REVIEWS

BOOKS RECEIVED

The Diagnosis and Treatment of Cardiovascular Disease. Edited by William D. Stroud, B. S., M. D., F. A. C. P., Professor of Cardiology, University of Pennsylvania Graduate School of Medicine; President of the American Heart Association; Treasurer and Member of Board of Regents, American College of Physicians; Licentiate of the National Board of Medical Examiners and the American Board of Internal Medicine; Cardiologist to the Pennsylvania, Graduate, Bryn Mawr, Abington Memorial, St. Christopher's and Children's Heart Hospitals. Two volumes. Cloth. Pp. 1825, illustrated. Price, \$18. Philadelphia: R. A. Davis Company, 1940.

Health Is Wealth. By Paul de Kruif. Cloth. Pp. 246. Price, \$2. New York: Harcourt, Brace and Company, 1940.

Daily Log. A Brief, Simple Accurate Financial Record for the Physician's Desk. Cloth. Champaign, Illinois: Colwell Publishing Company, 1941.

Dietetics Simplified. The Use of Foods in Health and Disease. By L. Jean Bogert, Ph. D., Formerly Instructor in Medicine, University of Chicago; Instructor in Experimental Medicine, Yale University; Research Chemist, Obstetrical Department, Henry Ford Hospital; Professor of Food Economics and Nutrition at the Kansas State Agricultural College. With Laboratory Section by Mame T. Porter, M. A., Nutritionist, State Department of Social Welfare, Albany, New York; Formerly Dietitian, Hospital of the University of Pennsylvania, Philadelphia; Chief Dietitian, U. S. Public Health Service, Base Hospital 27,

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TEMPLEBAR 4060 • 400 29th STREET, OAKLAND

Louisiana; Dietitian Private Pavilion, Mt. Sinai Hospital, New York. Second Edition. Cloth. Pp. 742. Price, \$3. New York: The Macmillan Company, 1940.

Methods for Diagnostic Bacteriology. A Complete Guide for the Isolation and Identification of Pathogenic Bacteria for Medical Bacteriology Laboratories. By Isabelle G. Schaub, A. B., Assistant in Bacteriology, Department of Pathology and Bacteriology, The Johns Hopkins University School of Medicine, and M. Kathleen Foley, A. B., Bacteriologist in Charge of the Diagnostic Bacteriological Laboratory of the Medical Clinic, The Johns Hopkins Hospital, Baltimore. Cloth. Pp. 313. Price, \$3. St. Louis: The C. V. Mosby Company, 1940.

The Practice of Medicine. By Jonathan Campbell Meakins, M. D., LL. D., Professor of Medicine and Director of the Department of Medicine, McGill University; Physician-in-Chief, Royal Victoria Hospital, Montreal; Formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh; Fellow of the Royal Society of Edinburgh; Fellow of the Royal Society of Canada; Fellow of the Royal College of Physicians, London; Fellow of the Royal College of Physicians, Edinburgh; Honorary Fellow of the Royal College of Surgeons, Edinburgh; Fellow of the Royal College of Physicians, Canada; Fellow of the American College of Physicians. Third Edition. Cloth. Pp. 1430, with 562 illustrations including 48 in color. Price, \$10. St. Louis: The C. V. Mosby Company, 1940.

The Rockefeller Foundation International Health Division, Annual Report 1939. Paper. Pp. 230, illustrated. New York: The Rockefeller Foundation, 1940.

The 1940 Year Book of Public Health. Edited by J. C. Geiger, M. D., Dr. P. H., Director of Public Health, City and County of San Francisco; Clinical Professor of Epidemiology, University of California. Cloth. Pp. 560. Chicago: The Year Book Publishers, 1940.

(Continued on Next Page)

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APPROVED BY AMERICAN COLLEGE OF SURGEONS

Service; Member of Board of Directors, American Social Hygiene Association and American Neisserian Medical Society. Cloth. Pp. 766, with 443 illustrations, 19 of them in color. Philadelphia: W. B. Saunders Company, 1940.

Vitamin Therapy in General Practice. By Edgar S. Gordon, M. D., M. A., Associate in Medicine and Instructor in Physiological Chemistry, University of Wisconsin, and Elmer L. Sevringhaus, M. D., F. A. C. P., Professor of Medicine, University of Wisconsin; Editor, Department of Endocrinology, The Year Book of Neurology, Psychiatry and Endocrinology. Cloth. Pp. 258. Chicago: The Year Book Publishers, Inc., 1940.

Obstetrics in General Practice. By J. P. Greenhill, B. S., M. D., F. A. C. S., Professor of Obstetrics and Gynecology, Loyola University Medical School, Chicago; Professor of Gynecology, Cook County Graduate School of Medicine; Attending Gynecologist, Cook County Hospital; Co-Editor of the Year Book of Obstetrics and Gynecology; Author of Office Gynecology. Cloth. Pp. 448, illustrated. Chicago: The Year Book Publishers, Inc., 1940.

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BOOKS RECEIVED

(Continued from Preceding Page)

Office Urology. With a Section on Cystoscopy. By P. S. Pelouze, M. D., Assistant Professor of Urology, University of Pennsylvania; Consulting Urologist, Delaware County Hospital; Special Consultant to United States Public Health

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BOOK REVIEWS

The Management of Obstetric Difficulties. By Paul Titus, M. D., Obstetrician and Gynecologist to The St. Margaret Memorial Hospital, Pittsburgh; Consulting Obstetrician and Gynecologist to the Pittsburgh City Homes and Hospital, Mayview, and to the Homestead Hospital, Homestead, Pennsylvania; Secretary of The American Board of Obstetrics and Gynecology. Second Edition. Cloth. Pp. 968, with 368 illustrations and 5 color plates. Price, \$10. St. Louis: C. V. Mosby Company, 1940.

This is the second edition of a book which proved very popular when introduced in 1937. The work consists of eight sections, divided into forty-two chapters, which cover: sterility, difficulties in diagnosis of pregnancy, complications of pregnancy, complications of labor, obstetric operations, complications of the puerperium, the newborn infant, and general, which covers antepartum and postpartum care, analgesia, and the like subjects. Seventy-five new illustrations have been added, and the text has been

lengthened by eighty-eight pages to deal more fully with the material, particularly the treatment of sterility, x-ray pelvimetry, obstetric operations, the management of toxemia, and obstetric analgesia and anesthesia.

While variety of opinion is given, for the most part the book contains in detail Dr. Titus' own personal opinion and experience, and with regard to management of difficulties and operative obstetrics, specific detailed instructions are given. The book can be read with profit by obstetrician and general practitioner alike and is one which should have a place in every library for ready reference.—R. L. H.

Artificial Pneumothorax.

Its Practical Application in the Treatment of Pulmonary Tuberculosis. Contributions by Saranac Lake Physicians to the Studies of the Trudeau Foundation. Editorial Committee, Edward N. Packard, M. D., John N. Hayes, M. D., and Sidney F. Blanchet, M. D. Foreword by E. R. Baldwin, M. D. Cloth. Pp. 300, illustrated with eighty-five engravings. Price, \$4. Philadelphia: Lea & Febiger, 1940.

This book is up to the usual high scientific standard of work characteristic of the Saranac Lake group of physicians. It will find an invaluable place in the library of the chest specialist, and will be of aid to the general practitioner contemplating treatment of occasional tuberculosis patients by means of pneumothorax. The work is written for the most part in an easily understood manner. Chapters dealing with all phases of the subject are included. The illustrations are somewhat disappointing in lack of sharpness of detail in the reproductions of radiographs. The bibliography is complete and the index is adequate.—F. D. H.

The Pathology of Internal Diseases. By William Boyd, M. D., LL. D., M. R. C. P., Ed., F. R. C. P., Lond., Dipl. Psych. F. R. S. C., Professor of Pathology and Bacteriology in the University of Toronto, Toronto; Formerly Professor of Pathology in the University of Manitoba, Winnipeg, Canada. Third Edition, thoroughly revised. Cloth. Pp. 874, illustrated with 353 engravings and 4 colored plates. Price, \$10. Philadelphia: Lea & Febiger, 1940.

This is a new edition of a familiar and very popular textbook on pathology. It reflects the advances in this field of medicine and retains the interesting style that has always been a fascinating feature in Boyd's works. In contrast to many textbooks of pathology, this work emphasizes the clinical aspects of the subject, a feature which makes it a valuable addition to the library of all physicians.

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

There is a particular charm in the easy style and vivid word pictures which give this author the knack of making dead information live.

The Diagnosis and Treatment of Pulmonary Tuberculosis.

By John B. Hawes, 2d, M. D., Late President of the Boston Tuberculosis Association; Director of the National Tuberculosis Association; Former Instructor in the Graduate School of Medicine, Harvard University, and Moses J. Stone, M. D., Assistant Professor of Medicine, Boston University, School of Medicine; Physician to the Chest Clinic of the Massachusetts Memorial Hospitals, Boston, Massachusetts; Physician to the Tuberculosis Clinics of the Boston Health Department; Assistant Physician, Beth Israel Hospital. Second Edition. Revised by Dr. Moses J. Stone with a Foreword by Richard C. Cabot, M. D. Cloth. Pp. 260, illustrated with 75 engravings. Price, \$2.75. Philadelphia: Lea & Febiger, 1940.

This book answers in a brief way many questions about tuberculosis which come to the mind of the practicing physician. It contains concise, sound modern information based upon the experience and knowledge of the authors. Some of the questions to which the inquiring practitioner can receive a brief and satisfactory answer include the differential diagnosis of tuberculosis; the difference between childhood and adult tuberculosis; the value of the sedimentation rate in prognosis and diagnosis; the length of time that pneumothorax should be continued and the

question of marriage and pregnancy in the tuberculous. There is an interesting outline of measures to prevent as well as to care for tuberculosis at the back of the book. If there is any criticism of the volume it is that the information is in some instances so brief that it is inadequate. For example, B. C. G. is discussed but one would hardly know whether it was a good, bad or indifferent procedure for clinical use from reading the too brief discussion regarding it.—P. C.

Cancer in Childhood and a Discussion of Certain Benign Tumors.

Edited by Harold W. Dargeon, M. D., F. A. A. P., Attending Pediatrician, Memorial Hospital for Cancer and Allied Diseases, New York; Associate Pediatrician, St. Luke's Hospital, New York; Associate Pediatrician, New York Foundling Hospital; Instructor in Pediatrics, College of Physicians and Surgeons, Columbia University. Cloth. Pp. 114, illustrated. Price, \$3. The C. V. Mosby Company, 1940.

The book is a very interesting, worthwhile discussion of the problem of neoplasia in infancy and childhood, with an introductory chapter by Dr. James Ewing. Dr. Ewing's chapter covers the general field of oncology, including distribution, clinical course, origin, congenital types of tumors, and the part played by heredity. In later chapters, tumors of various systems of the body are discussed, each being written by a specialist in the special field covered. Both rare and common types of neoplasm are discussed. References are generously furnished and details are sufficient to aid the reader in obtaining a larger knowledge of each field covered. The book is brief, but contains much worthwhile information.

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I hereby give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$_____ to be known as the _____ Gift, to be used and expended by said corporation for scientific, educational, or hospital purposes.

* * *

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I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California, the sum of \$_____, to be held as a fund, to be known as the [here insert name desired] Fund, the principal whereof shall from time to time be invested to the best advantage compatible with safety, and the income whereof shall be used and applied for scientific, educational, or hospital purposes.

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I give and bequeath unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used and applied for scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large an income as may be compatible with safety.

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I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California, to aid and further its scientific, educational, and hospital purposes, and to be known as the _____ Gift, the following described real property situate in the County of _____, State of California, and more particularly described as follows, to wit:

* * *

FORM OF CLAUSE OF WILL PROVIDING FOR DEVISE OF REAL PROPERTY

I give and devise unto Trustees Of The California Medical Association, a nonprofit corporation of California [here describe the property], the same, or the proceeds thereof, to be held as a perpetual fund, to be known as the [here insert name desired] Fund, the income whereof shall be used for and applied to the support and maintenance of scientific, educational, or hospital purposes. The said corporation shall have the power to sell said property and to invest and reinvest the proceeds arising from the sale thereof from time to time as it may deem advisable for the purpose of producing as large as income as may be compatible with safety.

* These Bequest Forms were discussed editorially in CALIFORNIA AND WESTERN MEDICINE, for March, 1936, p. 145, and June, 1936, p. 460.

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TWENTY-FIVE YEARS AGO

(Continued from Text Page 244)

Rights and Duties Under Health Laws.—The following extracts are taken from the Monthly Bulletin of the Los Angeles Health Department for August, 1915. It would not be a bad idea if every physician had some of these suggestions printed on slips and placed on the waiting-room table; it would help disseminate the simple knowledge and get the people to understand what all public health rules are—measures for their own good:

The health laws of your city have been made to protect you from disease and from early death. They are to make you live long. They are the result of long experience. They are to protect you and your family.

The city officials are your representatives. When they direct you to do certain things and not to do certain other things, it means that you and the people who live next door and the people who live on the next street, have made certain rules and regulations through them. Your representatives have made these in order to protect you; they have made them because such rules are necessary. Naturally you will want to live up to them.

If Health Laws are really to make more healthful conditions, you should do your share. You should do what the law says. You should urge your friends to do so as well. . . .

* * *

Sanitation Possibilities.—It seems well nigh impossible to make the people see what can be done in saving their health and their lives by proper sanitary measures, even in the face of such tremendous examples as Cuba, the Canal Zone, and districts where large government undertakings are in progress. To change, in a few months, the pest-hole

(Continued on Page 24)

How irritation varies— from different cigarettes

Tests made on rabbits' eyes reveal the
influence of hygroscopic agents*

- | | | |
|---|------------------|--|
| 1 | Edema 0.8 | Cigarettes made by the Philip Morris method |
| 2 | Edema 2.1 | Cigarettes made with no
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| 3 | Edema 2.7 | Popular cigarette #1
—made by the ordinary method |
| 4 | Edema 2.6 | Popular cigarette #2
—made by the ordinary method |
| 5 | Edema 2.7 | Popular cigarette #3
—made by the ordinary method |
| 6 | Edema 2.7 | Popular cigarette #4
—made by the ordinary method |

CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by Philip Morris.

CLINICAL CONFIRMATION:** When *smokers* changed to Philip Morris, every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

* * *

*N. Y. State Journ. Med. 35 No. 11,590. **Laryngoscope 1935, XLV, No. 2, 149-154

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TWENTY-FIVE YEARS AGO

(Continued from Page 22)

of the world—the Isthmus of Panama—into one of the healthiest places on the globe, one would think would be of sufficient importance to make everybody in every community sit up and take sufficient notice to demand the like conditions in his own "home town." But not so. . .

✓ ✓ ✓

Plague History.—Since publishing the brief note in regard to the position of the State Society and its direct influence in starting the campaign against plague in San Francisco, some years ago, our attention has been called to an omission by the author of the article mentioned. The *Occidental Medical Times*, edited by Dr. James H. Parkinson, Sacramento, was then alive—and very much alive, for Doctor Parkinson, as editor of that publication and as a member of the Council of the State Society, was extremely active in urging public support of the work and publicity of the facts in the daily press. It may not be clearly remembered after the passage of these years, just who was most active or most responsible for what happened, but it is certain that no two persons were more thoroughly roused or more active in their attacks upon the lethargic conditions of the time, than were the President of the Society, Doctor Evans, and Doctor Parkinson, of Sacramento.

✓ ✓ ✓

Extract of Liver, a Futurist Remedy.—To be a success, a proprietary must contain something new, or at least something regarding the therapeutic value of which the physician is ignorant. A remedy which fulfills this requirement is Filudine, a proprietary which has recently been investigated by the Council on Pharmacy and Chemistry (see

"Items of Interest," this issue). Filudine contains as its chief ingredient extract of liver along with extract of spleen and pancreas and thiarfeine which used to be "thiomethyl arsinatate" but now, according to the manufacturer, is "thiocinnamate of caffeine." The vast possibilities of extract of liver are appreciated when we learn that it contains "iron (the ferruginous function of the liver) phosphorized azatous bodies, lecithin, jecorin, glycogen, fats and ferments, such as proteolytic ferments, and the ferments of nucleic substances (nucleases, adenases, xantinoxydases, glyoxydases, and an uricolytic ferment; the ferments of ethers and fats, of hydrates, carbon, catalases and oxydases." We wonder if a cat's fondness for liver has any relation to its proverbial "seven lives."

From an Original Article on "The Modern Diagnosis of Hematuria," by Martin Krotoszyner, M. D., San Francisco.—Goethe in his immortal Faust terms blood a juice of extraordinary character, and bleeding from any source or organ is generally considered an awe-inspiring event among laymen; physicians, too, look upon hemorrhage, even in small or only microscopically recognizable quantities, as a serious, and if continuous, as an ominous symptom, from the early recognition and correct interpretation of which the health and comfort and, not rarely, the life of the patient may depend. . .

From an Original Article on "Clinical Records," by Eugene S. Kilgore, M. D., San Francisco.—1. Outline of Case Histories. The following outline of history and physical examination with remarks on the same is from the "Ward Reference Book" of the University of California Hospital. It is the prescribed form for use in the

(Continued on Page 26)

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courages all ages to drink milk.

*Medical Record, August 21, 1940

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

medical service of Dr. H. C. Moffitt, and with suitable modifications, it is used by the other services. It is put in the hands of medical students during the course in physical diagnosis and is thereafter followed by them in their case reports. It is not offered as anything original (in particular, we acknowledge indebtedness to Dr. Richard Cabot for suggestions), but merely as an example of a form which has been found satisfactory and useful in teaching and in standardizing the clinical records of the hospital. The adherence by interns to a standard arrangement of histories reduces the number of important facts which fail to get into the records and is an aid to the one who reads the histories in search of particular statements. The exact arrangement of the history form is largely a matter of individual preference, but certain points which merit special consideration are brought out in the "Remarks and Directions to Interns" which follow. . . .

From an Original Article on "Conditions in the Lower Back Involving the Sacro-Lumbar and Sacro-Iliac Articulations," by C. L. Lowman, M. D., Los Angeles.—The careful consideration of symptoms and findings in cases in which the lower back is involved has, during the past few years, opened up the way to fruitful results, clearing the way for the relief of a large class of cases, such as the so-called "sciatica," "sciatic rheumatism," "lumbago," "neuritis," etc., which have gone the rounds, getting varying degrees of help, or none at all.

We were formerly erroneously taught that the sacro-iliac joint was not a true joint, and that in the adult the sacrum

(Continued on Page 28)

STUDIES IN THE AVITAMINOSES



This page is the eleventh of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the November 9 issue of The Journal of the American Medical Association.

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great loss of blood, may be prolonged and difficult to control. The gum necrosis is usually accompanied by dental porosity. In the advanced stages of scurvy, the teeth are loosened due to destruction of the alveolar process, and the ulcerative lesions may extend to the mucous membrane of the cheeks and tongue. Gangrene has been described as a sequel of advanced untreated scurvy.



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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

fused with the iliac bones. Later, from observations in obstetric practice, in injury cases and in cases of pathologic lesions in this locality, various men were moved to closer study of the anatomy of this region. Goldthwait, especially, was one of the earliest to bring this to the attention of the profession. Albee, in dissections on forty or more cadavers, found true joint structures, synovia, cartilage, etc., and decided the sacro-iliac joints were true joints. . . .

From an Original Article on "The Diagnosis of Ureteral Calculi, and a Description of a Technic for Use of the Wax-Tipped Catheter in the Male," by Frank Hinman, M. D., San Francisco.—The symptoms of urinary stone are in no way diagnostic. The colic due to stone differs in no way from that due to blood clots, to kinks in the ureter, to adhesions or bands of constriction about it or to inflammation or congestion within. Ureteral colic is indistinguishable from renal colic: 80 per cent of 131 cases of ureteral stone at the Mayo Clinic had pain referred to the kidney, and appendiceal crises or gall-bladder attacks often simulate renal colic. Occasionally the pain due to stone in the lower end of the ureter will be so localized as to be suggestive. On the other hand a stone not infrequently becomes lodged in the ureter and produces serious renal damage without giving rise to symptoms of any kind whatsoever. . . .

From "Education at the Exposition."—The Palace of Education at the Exposition continues to be the center of educational conferences. The Public Health exhibits, par-

(Continued on Page 30)



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Stubborn cases of constipation usually yield to Petrolagar with Cascara.

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TWENTY-FIVE YEARS AGO

(Continued from Page 28)

ticularly those of the U. S. Public Health Service and the Health Department of Pennsylvania, have drawn crowds of interested observers.

The attendance in the section of the California Association for the Study and Prevention of Tuberculosis last month was over 15,000. . . .

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 244)

was 'undesirable as an employee.' 'We had no idea that a man who has previously been denied an application as ship's doctor would attempt to sign on as an ordinary seaman. A routine checkup made prior to sailing revealed the man's true identity and we simply dismissed him.' An action brought by the U. S. Government to determine whether or not he was properly naturalized in 1930 is pending in the federal court. According to Erben, who denies he is a Nazi sympathizer, he has been turned down for enlistment in both the army and navy because he is 'too old.' Erben gave his age as 43." (San Francisco Chronicle, September 19, 1940.) "Although his first venture to sail from here as an ordinary seaman ended in failure, Dr. Hermann Frederick Erben, Austrian-born brain specialist and adventurer whose citizenship is under Government attack, has tried again, it was revealed yesterday. He signed up for \$60 a month ordinary seaman's job at Tacoma on the Grace Line freighter *Staghound*, but his presence abroad was discovered by company officials as the vessel docked here, preparatory to sailing for South America, and they took

steps to remove him from the crew list. . . . Dr. Erben, 41, was surgeon aboard the freighter which acted as supply ship for the German pocket battleship *Graf Spee*, and on his return here the Government started court action to revoke his citizenship. A decision is expected within the next three months. . . ." (San Francisco Examiner, October 20, 1940.) (Previous entries, November, 1938; October, 1940.)

"Dr. C. F. Ott, wealthy Pacific Palisades physician, today faced a maximum sentence of a year and a half in jail or a \$1,500 fine, or both, as a result of his conviction yesterday on three misdemeanor counts of brutally beating and mistreating his three dogs. A jury in Municipal Judge Oda Faulconer's court brought in the verdict against the doctor, who, nine prosecution witnesses testified, had beaten, kicked and choked the three animals, Dash, Pal and Mickey. Doctor Ott will come up for sentence tomorrow at 2 p. m. and in the meantime has been released on his own recognizance. The jury of ten women and two men, who deliberated for almost two hours, cast only one ballot—unanimously for conviction. . . ." (Los Angeles Herald and Express, September 19, 1940.)

"The case of Dr. John H. Becker of Banning, interesting from a legal point because of the precedent it may have established regarding the powers of the state medical board in revoking licenses, apparently came to an end this week, with the decision going to the physician. Dismissing an appeal taken by the State from a Riverside County superior court decision, the fourth district court of appeal ordered

(Continued in Back Advertising Section, Page 34)

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CANNED FOODS AS SOURCES OF THE ESSENTIAL NUTRIENTS

● Early in this century, the existence of "accessory food factors"—the vitamins—was demonstrated by animal experiments (1, 2). Since that time, building upon information established by earlier investigators regarding the calorie, protein, and mineral needs of man, contemporary workers have developed a practical and fairly complete working knowledge of nutrition. At the present time, the fundamental human dietary requirements are considered in terms of some thirty substances of known chemical composition plus a number of factors whose chemical natures still await determination (3). Likewise, the dietary values of foods also may be discussed in terms of these same essential nutrients.

Viewed from a physiological basis, nutritional failures appear to be conditioned either by consumption of a diet deficient with respect to certain of the essential food factors or to altered processes in metabolism which prevent the efficient absorption and utilization of foods (1). Failures of the latter type can be corrected only by elimination of the defects in metabolism, or by administration of nutrients by routes which permit utilization. However, the vast majority of nutritional failures are associated with the consumption of diets deficient with respect to essential food factors. In the following quotation, the facts regarding malnutrition resulting from faulty diet are concisely stated (1):

"Three facts concerning nutritive failure are becoming increasingly obvious: first, that it does not come solely from lack of vitamins

but from deficiency of proteins and minerals as well; in certain of the lower animals, it comes even from lack of fats; second, that in America it is seldom complete; and third, that it is not, as a rule, the expression of a single nutritive fault. More often it is partial in extent and multiple in nature, with a clinical picture that is correspondingly lacking in detail and hazy in outline."

Although nutritional diseases are manifestations of the prolonged consumption of diets deficient with respect to amino acids, minerals, and vitamins, students of the problem agree (2, 4, 5, 6) that elimination of malnutrition is primarily a problem of increasing the variety of foods regularly eaten. Special emphasis should be placed upon the judicious consumption of familiar foods such as meats, (including glandular organs, poultry, sea food, and fish); eggs; milk in its many forms; milk products; fruits and vegetables; legumes; and the whole cereals and their various products. Thus, in its practical application (7), nutrition may be viewed as "an economic, agricultural, industrial and commercial problem, as well as a problem in physiology."

The nutritive values of canned foods have indeed been well established by means of numerous studies (8). By transforming foods, from the perishable condition in which they are harvested, to canned foods which may be stored for consumption in all seasons, the canning industry has rendered great assistance in carrying out the program designed to eliminate malnutrition in America.

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We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-fifth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

ON PUBLIC RELATIONS AND GOOD WILL

The Institution of "Committees on Public Relations."—During the last twenty-five years, an increasing number of state medical associations and their component county units, through by-law authority, have brought into being "committees on public relations."

Why?

The answer is found in the medical profession's gradual recognition of the importance of having scientific medicine represented by constituted groups, upon whose members may devolve the responsibility of maintaining, with an inquiring public, adequate and proper relations on matters of mutual concern.

* * *

Medicine Must Adapt Itself to a Rapidly Changing World.—During the last one or two decades, physicians throughout the land have begun to appreciate more and more that the industrial and somewhat collectivist period in which the world now lives has developed everywhere a change of mental attitude toward the medical profession. It may be true that this change, reflected in the relations which have always existed between individual patients and their respective personal physicians, to some may not at once seem so evident, but certainly a difference in feeling toward physicians, as a group, has become more than noticeable. Equally true it is that these distressing changes of thought and spirit are interlocked with economic, social welfare and other factors, over which the medical profession has little control.

When this spirit of doubt concerning the organized medical profession, which exists in the minds of a multitude of citizens, is analyzed, it is observable that with many laymen the distrust to which reference has been made has progressed into a phase of passive or active criticism, and in some cases even to marked antagonism toward the profession.

Fortunately, the medical profession has been able to comfort itself with the thought that these adverse elements have arisen, in good part, from a misunderstanding or lack of information concerning the mission and unselfish services that always—and today as much as in the past—have been rendered by physicians, not only in general public health activities, but through personal service

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

to a very large number of citizens having insufficient means, and the care of whose physical and mental ills has always been generously and unostentatiously assumed by physicians as part of their life calling.

* * *

Defensive Must Give Way to Offensive Methods.—However, today such good deeds are not enough to prevent onslaughts against scientific and organized medicine. Public health and altruistic service to the poor, in one sense, may be classed only as defense measures against the antagonists of the medical profession. What is needed is something more, namely, procedures for offense against the forces which, maliciously or otherwise, would tear down the system of medical practice, in order to try out plans that must assuredly lead only to a less devoted allegiance to the protection of the public health, and a poorer quality of medical service.

Moreover, such theoretical plans, once governmentally adopted, would be more than apt to make impossible the restoration of our present system; a system in which opportunity is given to every physician to produce his very best for the public health in the advancement of personal medical service.

* * *

Unbeliefs of Certain Propagandists.—Let it not be forgotten that some of the self-anointed lay reformers of medical practice are so obsessed with their ideas and exploitations that they seem altogether unable to comprehend that something must be at fault in their reasoning when they would tear down existing systems of practice that have given to these United States the lowest morbidity and mortality records of any civilized nation of the world. Many of these theorists and propagandists are also reluctant to acknowledge that, in America, the existing system of medical service is in harmony not only with the traditions of our land, but also with the well-considered conclusions and opinions of the great majority of physicians who are now in practice.

Owing to the extensive propaganda that has been carried on in the press and on lecture platforms against American Medicine, a situation has arisen in which the medical profession is confronted, not with a theory, but a fact, namely, that a changed and unfavorable reaction toward the medical profession as a whole has been created during recent years among many otherwise intelligent citizens who under former conditions, would have been friends and helpful proponents.

* * *

How May Existing Conditions Be Remedied? The question to be answered, then, is the determination of what are the best ways and means that will bring about a change in the thought and action of citizens whose kindly understanding of the medical profession has been alienated through the activities of well-meaning or other types of propagandists?

* * *

"Committees of Public Relations" Should Be "Committees of Good Will."—It is just here that Committees on Public Relations can be of great

value to public health and medical profession interests. For a "Committee on Public Relations" that does its work well is, in one and a real sense, nothing else than a "Committee on Good Will."

It may be quite true that many physicians feel that the merit of their altruistic and other services should make unnecessary any resort to measures that partake of the nature of organized effort to bring about, among all citizens, a clearer understanding and good will toward the medical profession. Nevertheless, when existing conditions are frankly studied, it must be apparent that the existence of good will is a necessary foundation element if scientific medicine and medical practice are to be maintained and developed as in the past, namely, through tried evolutionary methods rather than untried revolutionary theories.

* * *

Observations Concerning a Meeting Recently Attended.—The meaning and value to a business, of proper understanding by the public, was thrust upon us the other evening at a meeting of the Pacific Railway Club, to which the editor had been invited. The four speakers were the representatives of the public relations departments of the American Association of Railways, the Santa Fe, the Union Pacific and Southern Pacific Railway Companies, organizations representing investments of millions and millions of dollars. In the early years of their development, it may be truthfully said that their executives probably paid little or no attention to maintaining cordial relations with the public; certainly not along the lines under which their committees on public relations of the present period so ably function.

It was illuminating to hear these four key men of their respective organizations, in their addresses, always come back to the basic proposition: that every employee, no matter how humble his position, was construed to be a real factor in promoting the interests and further development of his particular company; and that the success of each railway rested upon the composite influence produced by all the employees upon the public as a whole; and particularly among those groups with whom they had business or other contacts.

* * *

Application to the Profession of Medicine.—That thought transposed, therefore, when made to apply to the medical profession, could then be stated in somewhat the following terms:

1. The place occupied by the medical profession in the public mind is largely that which is made by individual physicians as they work with the groups of citizens who come to them as patients.

2. The reaction of the individual citizen toward the medical profession, as a whole, will depend in good part upon the relations which that particular citizen has had with individual members of the medical profession, both professionally and otherwise.

3. A favorable opinion by the public concerning organized medicine must have as a basis a clear understanding by the public, that the objectives of the medical profession always center around the highest quality of personal medical service, and

the promotion of public health interests, through procedures mutually acceptable.

Or, to put it otherwise, individual citizens primarily judge the medical profession by the kind of service and consideration they receive from individual physicians. However, the composite thinking and conclusions of the public at large, while based largely and mostly upon the above, are also dependent upon, and in no small measure, on how the constituted exponents of organized medicine conduct themselves in relation to public interests, in so far as the conservation of health and life are concerned.

* * *

In Conclusion.—The thought may be suggested that governmental supervision or domination of medical practice will not work for the advancement of scientific medicine. Also, that scientific medicine in the existing world is greatly dependent for the protection of its interests and progress upon organized medicine.

The task, then, of organized medicine is to convince the public that the objectives of scientific and organized medicine, as they now exist—with evolutionary modifications from within, as may be needed from time to time—are designed to and do promote, better than through other suggested systems, the conservation of public and personal health.

Also, that in these endeavors, in order to safeguard the existing system of medical practice, every physician has a real place; his individual services becoming a part of the record of achievement that will make it possible for medical committees on public relations (good will) to properly function as promoters of scientific medicine and the conservation of the public health. Wherefore, again to emphasize the importance of the rôle of the individual physician in his relations to the public, these comments are submitted.

FALL AND WINTER POSTGRADUATE CONFERENCES IN CALIFORNIA

Value of Graduate and Clinical Conferences. Medical men and women are almost a unit in their approval of the value and desirability of graduate refresher courses, no matter by what name such courses may be designated (postgraduate or intermittent courses, clinical conferences, refresher meetings, or graduate assemblies). The unanimity of opinion concerning the commendable objectives is not supported, however, by equally unanimous effort in promoting the success of courses that are offered. Experience in many states and communities has demonstrated, and on many occasions, that in order to make a graduate or clinical conference measure up in proper results, the whole-hearted support of one or more committeemen is needed; not only in planning the course, but in constantly being on the job until the program is carried through to successful completion. A major problem, therefore, which state postgraduate committees are called upon to solve, is to find and secure the appointment of a local committee, whose members will complete, in efficient manner, program

arrangements that may have been made for their district.

* * *

Postgraduate Committees: Careful Selection Necessary.—Officers of county medical societies bear a large share of the responsibility in this matter since it is they who usually appoint members of a postgraduate committee. If a local committee is not well selected, the following results may soon become evident: (1) money expended is wasted, at least in part; (2) guest speakers and demonstrations have been robbed of time that busy men can put to better advantage; and (3) physicians living in the community in which a conference is scheduled, and who disarrange their office hours to permit attendance, likewise are losers when a postgraduate or clinical conference has been poorly managed.

With this foreword on some of the difficulties met with in the promotion of graduate meetings, appeal may be made to the program committee of every component county unit of the California Medical Association to give serious thought to plans for a clinical or refresher course conference, to be held at some convenient time during the next several months.

* * *

Factors to Be Considered.—State medical associations sponsoring postgraduate assemblies have been most successful when working along lines that are in harmony with local facilities and needs. The local committee must decide, therefore, what city or place of the district is the best center, in relation to geographical territory to be covered, and to transportation, institutional, and other conditions.

Next comes decision on the scientific topics that will probably have greatest value and appeal to the physicians expected to participate in the clinics. Connected therewith, naturally, is the problem of securing an adequate amount of clinical material.

Then it must be determined who shall be the guest speakers, and consideration must be given to their reputations, not only regarding their knowledge of subjects to be discussed, but also their ability to make such discussions both interesting and of the most practical value. The problems of furnishing transportation, with its attendant cost and the attendance time of such special speakers, and provision for other hospitality, must also not be forgotten.

Finally, the days and hours on which conference or sessions are to be held should be settled. Concerning these items, it should be stated that, by and large, more men may find it possible to attend on Saturday afternoons (say between 4 and 6 o'clock in the afternoon), with a follow-up or after-dinner meeting between 8 and 10. In a two-day conference, the Sunday morning meeting can be arranged to run from 9 o'clock until noon, leaving the afternoon free for fraternal or social programs. However, during the open seasons for hunting ducks and other game in California, other days may be preferred.

In the near future, postgraduate committees will receive further information from the Association Secretary, who also functions as the secretary of

the Committee on Postgraduate Activities. Component county societies that have not appointed postgraduate committees for the current year are now requested to do so.

ON VARIOUS TOPICS

Indictments Against Officers of the American Medical Association: Washington Trial Indefinitely Postponed.—At the time this is written, information has been received that the trial of the case of the *United States vs. American Medical Association*, recently reopened at the instance of the attorneys for the Federal Government, before one of the District of Columbia courts, has been indefinitely postponed.

This news is as gratifying to physicians as was regrettable the initial announcement of the action by the Government, through which officers of the American Medical Association, District of Columbia Medical Society, and members of county societies in other States were charged with a violation of the 1891 Sherman Antitrust Act.

Just when, if ever, the case now will be brought to trial is not known. The action of the Government in deciding not to proceed with the case at this time will assure greater success for the American Medical Association in its efforts to promote medical preparedness. Those plans can now be prosecuted with that vigor and success so much needed if the United States is to be adequately made ready in medical matters—in case certain emergencies arise.

It may not be amiss to reprint here for record, and for perusal by Association members who did not see the article in *The Journal of the American Medical Association* (for June 19), the opening editorial comment in that number where, under the caption "Important Announcement," the following statement appeared:

At this time *The Journal* is compelled to inform its readers that the work of the American Medical Association as a body, including its contribution in aid of the national defense, must suffer serious interference during the next two or three months. The Secretary and General Manager of the American Medical Association, the Editor of its publications, the Secretary of its Council on Medical Education and Hospitals, and the Director of its Bureau of Medical Economics must be absent from the headquarters office during those months, since they are required to attend, as defendants, their trial in the United States District Court for the District of Columbia on the indictment there returned against them and against the American Medical Association, the Medical Society of the District of Columbia, the Washington Academy of Surgery, the Harris County (Texas) Medical Society and fifteen prominent physicians in Washington, D. C. The indictment charges all defendants with having conspired to violate Section 3 of the Sherman Antitrust Act. The Association respectfully asks the indulgence of the medical profession and the public throughout the United States for any deficiencies which may result from this unavoidable and unfortunate condition.

When the American Medical Association was requested to assist in the national emergency now confronting this country, its House of Delegates voted unanimously and without dissent to give whole-hearted coöperation and support. The officers, the headquarters office, the Committee on Medical Preparedness, the state chairmen and numerous other physicians have been and are now engaged intensively in that service, and they expect to continue therein. In advising physicians and the public of this apparent discouragement in the essential work that it has undertaken

to perform, the Association desires to say that it will do its utmost to overcome all obstacles to medical preparedness. We assure the medical profession that it will never be said, either in criticism or in comment, that the Association failed its country in any hour of need, no matter what obstacle might arise to interfere with the otherwise expeditious and efficient service that this country deserves in this critical hour.

The Journal has indicated repeatedly the difficulties associated with medical mobilization and the nature of the work now being carried on to provide all the various arms of the government with physicians. Even though this work will be seriously hampered by absence from the headquarters office of some of the key men who have been charged with this duty, every possible method will be utilized to carry on the work as expeditiously as can be done. Plans are also being developed for the handling of correspondence, finance, personnel and all the other multitudinous affairs associated with the work of this great organization to the best extent of which the organization is capable, so that the medical world and the public may not suffer by this serious interference with the provision of medical service and the dissemination of knowledge of medical advancement.

* * *

On Medical Preparedness.—In this issue of CALIFORNIA AND WESTERN MEDICINE considerable space is given to the subject of medical preparedness, the special attention of members of the California Medical Association being called to the following items:

1. *Importance of Returning Questionnaire Blanks to the American Medical Association Headquarters in Chicago.*—At the joint meeting of the national committee and state chairmen of the Committees on Medical Preparedness, held in Chicago on September 20, the California representatives (Dr. Charles A. Dukes of the national committee and Dr. Philip K. Gilman, chairman of the California committee) were informed that only 54 per cent of the licensed physicians of California had returned the questionnaires originally sent to them from Chicago.

Recently, lists of those physicians whose questionnaires were not on file in that city have been received at the central office of the California Medical Association. Questionnaire blanks will be forwarded from San Francisco to the physicians who did not reply to the first request, and it is to be hoped that the blanks will be filled in and promptly mailed to the headquarters of the American Medical Association, at 535 North Dearborn Street, Chicago. The lists reveal the fact that about 2,500 members of the California Medical Association failed to transmit the information requested. In addition, some 3,500 physicians who are not members of the State Medical Association, likewise failed to remail their blanks.

The American Medical Association has taken on this work as one of its contributions to national defense, the definite purpose being to make it possible for the medical corps of the United States Army and Navy, and of the Public Health Service to have available, on short notice, essential information concerning the training and qualifications of every physician who is now in practice in the United States.

Physicians who fail to send in their blanks may later find themselves the victims of embarrassing circumstances, should unwelcome assignments be received from Washington.

All physicians who have not returned their replies are urged to do so when the follow-up blanks are received. To insure a prompt response for the questionnaires, the coöperation of key-men in the county societies, and of members of the Woman's Auxiliaries has been enlisted. The California Committee on Medical Preparedness urges the fullest coöperation in this important work.

2. *Lists of Medical Examiners for Selective Service.*—For the convenience of members, a list of California physicians who are attached to the various selective service boards is given in this issue (on page 224). Readers are requested to call attention to any errors or omissions. The list was received from the office of the Adjutant-General of California, and is of October 20, 1940, date.

3. *Instructions to Medical Examiners.*—Also, for reference convenience of physicians who have accepted places as medical examiners, CALIFORNIA AND WESTERN MEDICINE prints a "Bulletin of Information," issued by the military authorities, concerning the examinations of draftees. It may be desirable, therefore, to mark and lay aside this issue for possible future use (see page 229).

4. *Other Information.*—Other items in connection with medical preparedness are also presented. Members who have heretofore given only casual attention to the progress being made in medical preparedness may find some of the information of considerable interest.

It may not be out of place to add that Doctors Charles A. Dukes and Philip K. Gilman report that excellent understanding and full coöperation have been had with both federal and state authorities, whom they have found it necessary to consult while engaged in carrying into execution for California, adequate plans on medical preparedness.

* * *

Annual Session, Del Monte, May 5-8, 1941.—Members are again reminded that the annual session of the year 1941 will be held in Hotel Del Monte, Monday, May 5, to Thursday, May 8, inclusive. The usual study groups (radiology, clinical pathology, heart symposia, and others) will hold conferences on Sunday, May 4. The April issue of the OFFICIAL JOURNAL will present the preliminary program announcements.

As stated in former issues, the four morning programs will be given over to general sessions to be held in the large auditorium: (on Monday, organization topics; on Tuesday, medical papers and clinical-pathologic conference; on Wednesday, surgical subjects; and on Thursday, current advances in medicine, surgery, and the specialties). Also, during the morning hours, medical and surgical films will be displayed in one of the larger assembly rooms. The four afternoons will be allocated to the twelve scientific sections—medicine, surgery, and the specialties. The plan in vogue in former years, of keeping Tuesday afternoon free for entertainment has been discontinued, thus permitting specialty groups to hold their meetings in day-to-day sequences.

Any member of the Association who has in mind the presentation of a paper should promptly write to the secretary of the Section before which the

paper would be read (the roster of section officers appears in every issue of CALIFORNIA AND WESTERN MEDICINE, on advertising page 6). Correspondence concerning films and scientific exhibits should be taken up with the Association Secretary, who also functions as chairman of the Committee on Scientific Work. Prizes and certificates of merit will be awarded for outstanding scientific exhibits.

Communications concerning hotel accommodations and reservations should be addressed to Hotel Del Monte, Del Monte, California.

* * *

On Coöperation of California Medical Association with State of California Departments.—

One of the objectives of organized medicine is the promotion of kindly relations between groups of doctors on the one hand, and, on the other, with divisions or bureaus of the State of California that may have responsibilities in the care of sick citizens, or in the conservation of the public health. This is easily understood, because physicians, as representatives of scientific medicine, are interested in all activities that make for the prevention of sickness and prolongation of life.

Recently, officers of the State Association, and in particular its chairman, Dr. Philip K. Gilman, have had a number of informal conferences with certain groups in which matters of public health and welfare were frankly discussed, and resulting therefrom plans have been suggested whereby some of the problems which constantly confront certain departments of the State and its constituent counties may be solved to somewhat better advantage in the future. Mention may be made of:

1. A proposal to allot a place on the program of the first general meeting of the May 5-8, 1941, annual session to representatives of the California State Board of Public Health for presentation of matters of mutual interest.

2. A plan for what is hoped will result in an harmonious settlement of certain child welfare activities and complications that have gradually developed in one of the San Francisco Bay counties; and

3. A recent conference with representatives of the State Relief Administration of California, in which plans were considered for closer coöperation in the care of citizens on relief, with the possibility of ultimate adjustments that may be of considerable scope and importance.

All this, as it should be, is in line with modern-day policies. It is not out of place to remember that what the State Medical Association is doing in relation to problems affecting the commonwealth, could well be patterned after by those county medical societies whose members are trying to meet and solve analogous problems in their respective districts. It should not be forgotten that every individual and group with whom a physician or a medical society has cordial contacts makes for better understanding and friendships—a condition very much needed if the medical profession is to be victorious in some of the battles still ahead.

* * *

Readjustment of Administrative Duties in the Central Office.—During the last half-dozen years the Council has appointed several special

committees to bring in reports on ways and means, whereby the facilities of the Association's Central Office might be maintained in a state of maximum efficiency. During this period the rapid increase in membership, and a mass of unforeseen but very important work, in which basic policies of the Association, extensive survey studies, and the expenditure of large portions of the Association's reserve funds were frequently involved, threw upon the Central Office much extra work. The Council, the Executive Committee, the Special Committees, and the Association Secretary were all called upon to assume new responsibilities and give much additional time, thought and effort to bring about a solution of the various problems, as these came to the front one after the other and all in somewhat rapid succession. Examples of such unforeseen lines of special endeavor could include: the Alameda Plan, proposed at the Riverside annual session of 1934; the proposed statutes presented to the California Legislature and drafted to apply to medical service and nonprofit hospitalization plans; the California Medical Economic Survey; the activities to be carried on through the special assessment of July 1, 1939; the compulsory health legislation espoused by the present State Administration; and last, but not least, California Physicians' Service. Each of these projects and others of similar nature meant that a heavy load of extra duties was thrust upon the routine of the Central Office and Association Secretary, not infrequently disarranging the regular work for longer or shorter periods.

At Coronado, in May last, in response to resolutions adopted by the House of Delegates, the Council again took up the matter and appointed a special committee, consisting of Council Chairman Philip K. Gilman of San Francisco, President Harry H. Wilson of Los Angeles, and President-Elect Henry S. Rogers of Petaluma, to work out the details of arrangements that had been discussed. The report of the Special Committee, which was approved by the Executive Committee and by the Council, appears in this issue, and it is hoped that members will take the time to scan it.

In the meantime, the attention of the officers and members of the component county medical societies is called to the appointment of an additional administrative officer, Mr. John Hunton, who henceforth will act as the executive secretary of the California Medical Association, and whose name will soon become familiar through communications going forward from the headquarters office. Members are requested to give him all possible coöperation in the performance of his duties. Further information on this subject may be gleaned from the report of the special committee, which will be found in this issue, on page 219.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 219.

EDITORIAL COMMENT†

"BINOMIAL" THEORY OF TYPHOID FEVER

According to experimental data recently reported by Magrassi and Galli¹ of the Institute for General Clinical Medicine, Rome, Italy, typhoid fever is not a simple bacterial infection. Their evidence suggests that the essential etiologic factor is an ultravirus growing in adherent symbiosis with the nonpathogenic typhoid bacillus. There is also evidence that this hypothetical virus is also capable of "activating" the normal intestinal flora and thus serving as a symbiotic etiologic factor for numerous nontyphoid intestinal infections.

That many infectious diseases are of complex or "binomial" etiology has been adequately demonstrated during the last decade. Swine influenza, for example, has been convincingly shown to be due to the synergic or concurrent action of a subpathogenic filterable virus and the relatively nonpathogenic swine influenza bacillus. The possibility that typhoid fever is of similar synergic etiology was suggested to the Italian clinicians by their study of the dissociable virulence factor ("Vi-antigen") from the typhoid bacillus. Freshly isolated, fully virulent typhoid bacilli are relatively rich in this so-called "Vi-antigen," which factor, however, is readily dissociated from the bacilli. A mere suspension of the bacilli in physiologic salt solution is sufficient to set free most of this adherent capsular colloid. The analogy between this dissociable capsular virulence and bacteriophage suggested that the Vi-antigen might be a filterable virus.

To test this concept filtrates from partially autolysed virulent typhoid bacilli were injected intravenously, intraperitoneally or intracerebrally into young rabbits (circa 1,500 grams). Immediate toxic symptoms were noted after massive intraperitoneal injections. With relatively small doses of Vi-antigen factors injected intracerebrally, however, there was usually a latent period of from three to ten days before the appearance of demonstrable symptoms. Increasing muscular weakness with diarrhea and a rapid loss of weight were then noted. Two-thirds of their cases ended fatally by the fifteenth to the fortieth day. On autopsy the brain, spleen, liver, and heart blood were usually found to be bacteriologically sterile.

Ten per cent aqueous emulsions were made from these autopsied organs, cellular detritus and possible bacterial contaminants being removed by centrifugation and porcelain filtration. The filtrates would reproduce the emaciating diarrheal disease in all of its original severity, if injected intracerebrally into young rabbits. By this technique the filtrate infection has been propagated for six consecutive generations without demonstrable loss of

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Magrassi, F., and Galli, F.: *Boll. R. Acad. Med. di Roma*, 64:7, 1938; *Arch. ges. Virusforsch.*, 1:325 (Feb.), 1940.

virulence. In one such series, for example, sixteen (80 per cent) out of twenty rabbits injected with the initial filtrate died of emaciating diarrhea. In the fifth passage of this series, six (75 per cent) fatalities occurred in eight injections.

Rabbits recovering from the passage virus were tested serologically, 75 per cent of them showing relatively high titer typhoid agglutinins, while 25 per cent gave negative Widal reactions.

From experimental evidence of this type, Magrassi and Galli conclude that typhoid fever must be regarded as a synergic disease, the etiologic factor being the nonpathogenic typhoid bacillus in adherent symbiosis with a typhoid virus (Vi-antigen). Dissociated from the bacillus, the virus is able to produce nontyphoid enterocolitis by "activating" *B. coli* or other normal intestinal bacteria. The virulence factor is able to stimulate the production of typhoid agglutinins when grown in symbiosis with *B. coli*.

While the work of the Italian investigators has not yet been confirmed by American bacteriologists, their suggested "binomial" theory is in line with the newer knowledge of bacterial dissociation and virus synergism. If confirmed, their theory eventually may take its place as one of the most important basic contributions to medical science of the present generation. Most American bacteriologists, however, are skeptical of its confirmation.

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MAPHARSEN AS AN ANTISYPHILITIC ARSENICAL

Thirty years ago, Paul Ehrlich first synthesized and studied the chemical named amidophenoarsenoxid, otherwise known as arsenoxid, and commonly known today as mapharsen. Its use in human beings was not recommended at that time because he regarded it as highly toxic, and as possessing a lower chemotherapeutic index than arsphenamin. Mapharsen is a pure, stable chemical, which is readily soluble, and contains a low arsenical content (about one-tenth that of neoarsphenamin in comparable therapeutic doses).

On the basis of experimentation, Tatum and Cooper found in 1932 that mapharsen had a higher therapeutic index for syphilis in rabbits than any other syphilitic agent. This experimental evidence warranted its trial in human syphilis, and since then a great deal of literature has appeared, most of which agrees on the favorable effects of mapharsen on the various forms of syphilis.

In considering the value of mapharsen as an antisiphilitic agent, it is interesting to note the results obtained by Chargin et al. in the treatment of 188 cases of early syphilis with mapharsen and bismuth, as compared to results obtained by Stokes et al. in a series of 169 cases treated similarly, but with arsphenamin or neoarsphenamin and bismuth. In this series, satisfactory results with mapharsen were obtained in 84 per cent of the cases. This compares favorably with the 80 per cent satisfactory results noted with neoarsphenamin or arsphenamin.

Mapharsen is still an experimental drug, although admittedly it has had extensive clinical trial in the last eight years. To date it has apparently shown itself to be as effective an arsenical as neoarsphenamin in the treatment of the various manifestations of syphilis, as evidenced by the disappearance of spirochaetes from early infectious lesions, healing of early and late skin manifestations, reversal of serology, and prevention of syphilis in new-born infants. Although it probably will prevent the later complications (such as paresis, tabes, and cardiovascular syphilis) where adequately used, about twenty years must pass before this can be definitely stated.

To date, in over five million injections only two fatalities have been reported (Simon and Iglauer, Rein and Wise). This is much less than one would expect from neoarsphenamin. It has been particularly noted that instances of blood dyscrasias, severe or exfoliative dermatitis, liver damage, and other serious and at times fatal reactions occurring with neoarsphenamin are very rare. No case of nitritoid reaction due to mapharsen has been reported.

Some patients, however, cannot tolerate mapharsen without experiencing nausea and vomiting. Pain along the course of the vein and extending up the arm to the shoulder may also occur. While these are not serious reactions, they are disconcerting to the patient. Despite these minor reactions, it may be stated in brief that in view of its low toxicity, ease of preparation and administration, and the excellent results so far obtained, the further use of mapharsen as an antisiphilitic remedy is justified.

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Reports Inflammation of Skin After Wearing of Nylon Hose.—Four cases of dermatitis (inflammation of the skin) of the legs and thighs following the wearing of Nylon stockings made by one manufacturer are reported by S. J. Fanburg, M. D., Newark, N. J., in *The Journal of the American Medical Association*. In his preliminary report of the cases he says they "suggest that the dye or finish used in preparing the hose in question may have been a primary cutaneous irritant, while the Nylon itself is probably innocuous."

Patch tests made on the four women with undyed and unfinished Nylon were negative, he reports, whereas in all four cases strongly positive reactions to the finished product and the residue of an ether extract were obtained. Doctor Fanburg says that the E. I. DuPont de Nemours Company states that Nylon yarn is manufactured by it and sold to various mills, where the material is made into hosiery and then dyed and finished.

"This note," the doctor says, "is made so that others may be on the lookout for similar cases and to call attention to the need, for the manufacturers, to warn the public of the possibility of reactions to this product."

While the school teacher has not more tuberculosis than the average adult, next to the family she provides the greatest opportunity for close prolonged contact with the school child. To require the teacher to provide a health certificate, including chest films, would serve to remove this reservoir of infection.—D. O. N. Lindberg, M. D., *Illinois Medical Journal*, October, 1935.

ORIGINAL ARTICLES

PRIMARY CARCINOMA OF THE LUNG:
THE IMPORTANCE OF EARLY DIAGNOSIS IN
INCREASING OPERABILITY AND
CURABILITY*By PAUL C. SAMSON, M. D.
Oakland

AND

EMILE HOLMAN, M. D.
San Francisco

PRIMARY cancer of the lung is no longer a pathologic curiosity. Reliable statistical studies, covering many thousands of autopsies, have shown that bronchiogenic malignancy now comprises approximately 10 per cent of all carcinomas.¹ We are, then, dealing with a lesion which is relatively common and in which an early diagnosis must be made if a cure is to be expected. At present, wide surgical removal by pneumonectomy is our most certain means of cure. Awareness of the frequency of primary carcinoma of the lung must warn the physician to search for confirmatory evidence whenever an unexplained thoracic symptom-complex is presented. This report concerns early symptomatology, and outlines the further diagnostic procedures which are necessary when bronchiogenic carcinoma is suspected.

* Read before the Section on General Surgery of the California Medical Association at the sixty-ninth annual session, Coronado, May 6-9, 1940.

From the Department of Surgery, Stanford University School of Medicine, San Francisco, California.

SYMPTOMS AND SIGNS

Persistent cough is an early symptom in nearly all cases. At first it is nonproductive and hacking in character. When sputum first appears it is usually mucoid, later becoming purulent when infection has developed beyond an obstructing neoplasm. Wheezing due to the partial obstruction of a large bronchus is frequently a prominent symptom. Blood-streaking in the sputum may occur early in the disease, but its complete absence is not unusual. Large hemoptyses are uncommon except as a late development.

Many patients attribute their difficulties to a cold, to influenza, or to a pneumonia which did not clear up properly. The persistence of fever, night sweats, and productive cough for many weeks, following an acute respiratory episode, should be regarded with great suspicion. Unless the history is properly evaluated, symptoms of continuing or recurrent pulmonary infection may entirely overshadow the evidence of an obstructing neoplasm. In such patients, pulmonary tuberculosis and other chronic infectious diseases may be readily ruled out by adequate sputum examination.

Occasionally patients with a chronic cough, due to bronchitis or bronchiectasis, note a change in the cough. There may be an alteration in tone, and the cough becomes more irritating. The sputum changes character and there may be blood-streaking. This change in "cough habit" should be regarded with exactly the same suspicion as one regards a change in bowel habit when a carcinoma of the colon is suspected.

Thoracic discomfort often occurs due to atelectasis, pulmonary infection, or pleural irritation. Constant severe chest pain is uncommon as an early



Fig. 1

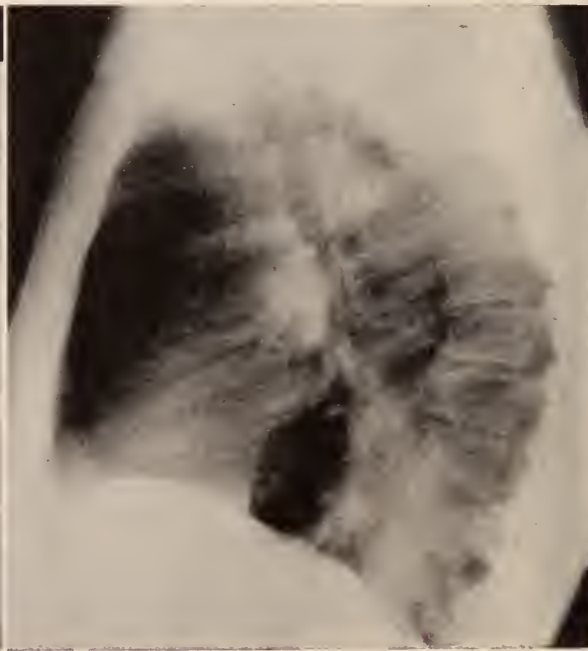
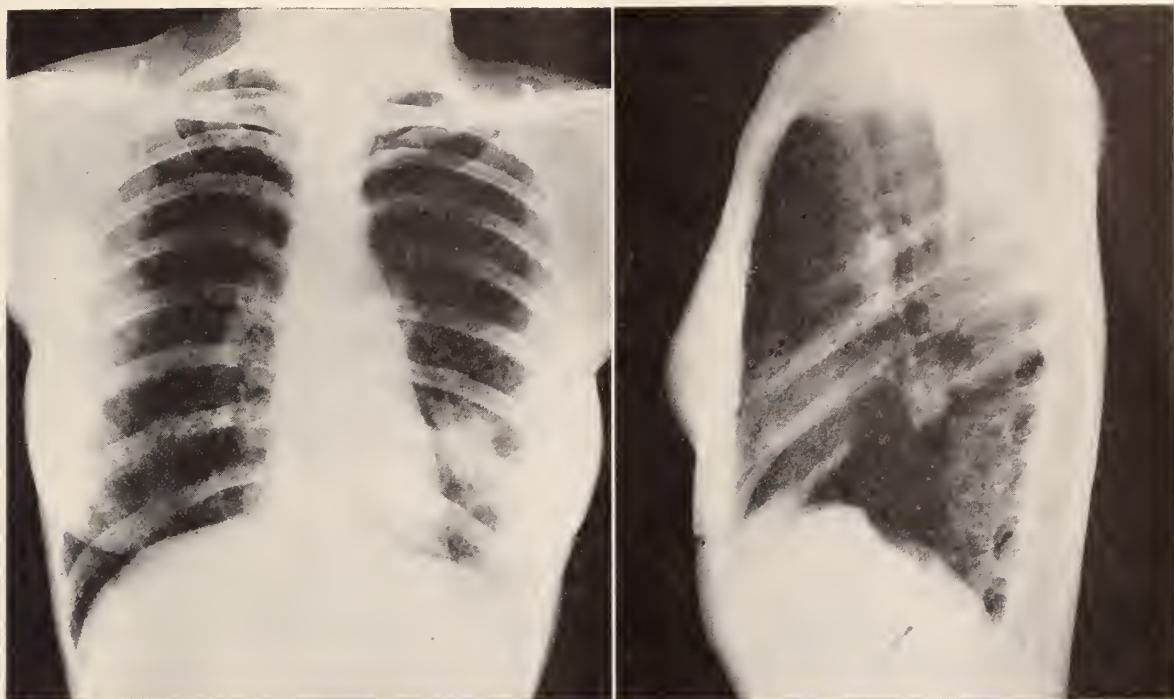


Fig. 2

* Fig. 1.—Complete obstructive atelectasis of left upper lobe. Preoperative pneumothorax present. (Case 1.)

* Fig. 2.—Wedge-shaped lobular infiltration in left lower lobe, lateral projection. (Case 2.)

* Figs. 1, 2, and 3 reprinted from *Western Journal of Surgery, Obstetrics and Gynecology*.



* Fig. 3.—Frontal and lateral projections showing rounded density in left lower lobe (Case 4). Biopsy secured by careful nonvisual exploration of successive tertiary bronchi.

symptom. Moderate weight loss and slight anemia may be present. In the face of other suggestive findings, age should not be taken into consideration, since carcinomas of the lung have been reported in patients under twenty.

There are no characteristic objective findings in early pulmonary cancer. Physical signs may be entirely absent. Occasionally a small neoplasm may cause a total atelectasis with resultant cardiac and mediastinal shift. Localized wheezing and coarse rhonchi are of importance when present. The development of nerve palsies (Horner's syndrome, recurrent laryngeal and phrenic paralysis), vascular obstruction, or esophageal deviation usually indicate that the neoplasm is inoperable.

DIAGNOSIS

When a bronchiogenic neoplasm is suspected, adequate roentgen examination must be the first step in diagnosis. This should consist of fluoroscopy, followed by frontal stereoscopic and lateral films. The chief value of fluoroscopy is to determine whether or not an obstructive emphysema is present. Adequate film studies are necessary for accurate localization. Many neoplasms do not present a characteristic picture because of obscuring parenchymal infection.² Irregularly rounded shadows, with faint peripheral radial striations, may be seen. Persistent wedge-shaped lobular infiltrations should be regarded with suspicion. Lobar atelectasis is not uncommon (Figures 1-4). Occasionally the roentgenogram reveals no evidence of disease. If symptoms persist, however, further diagnostic procedures should be carried out.

Bronchoscopy, with biopsy, probably is the most important single procedure which we possess for the determination both of diagnosis and of opera-

bility. This examination always should be advised without hesitation. In competent hands the hazard and discomfort are minimal.

As with other diagnostic procedures, bronchoscopy is not infallible. Microscopic examination of tissue may not substantiate the visual impression of tumor. In this case bronchoscopy should be repeated immediately. Should the first examination fail to reveal neoplasm, and should suspicious symp-

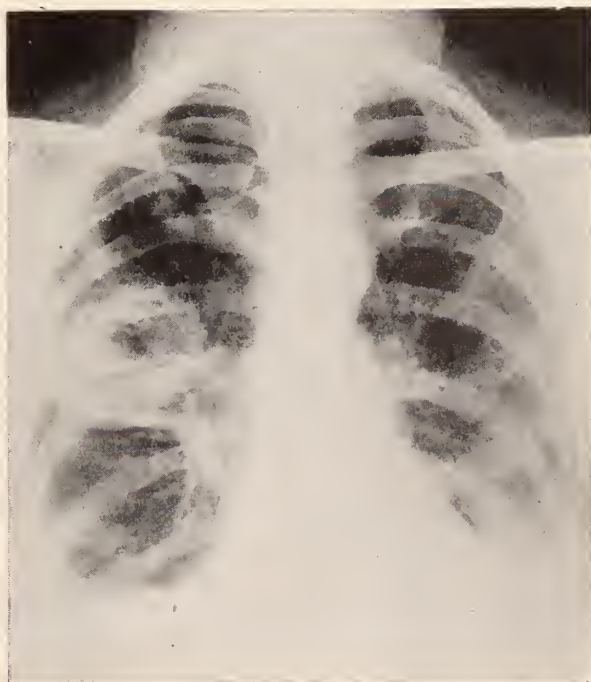


Fig. 4.—Large, irregular cavity in right upper lobe. Walls unusually thickened. "Excavating carcinoma." Preoperative pneumothorax present. (Case 6.)



Fig. 5.—Biopsy instruments most frequently used. (a) Square-end basket forceps with cutting edge. (b) Sharp-edge cup forceps, extremely useful for probing smaller bronchi beyond bronchoscopic vision. In such instances biopsy material is secured by a scalping technique rather than by biting.

toms continue, a second bronchoscopy within a few weeks is imperative. In approximately 75 per cent of cases a definite diagnosis will be established bronchoscopically. The careful study of pre-bronchoscopic roentgenograms may be of great aid if the lesion is not visualized at bronchoscopy. Accurate roentgen localization often permits successful "blind biopsy" with curette or cup-forceps (Figure 5). Holinger³ has used biplane fluoroscopy for the same purpose, but this apparatus is seldom available. In rare instances the induction of pneumothorax causes sufficient downward bronchial angulation to permit visualization of an otherwise inaccessible lesion. If the suspected neoplasm is not visualized, but blood-streaked sputum is seen, this should be collected in a separate container, fixed, and paraffin sections made.

Bronchoscopy, likewise, gives valuable aid in judging as to the possibility of pneumonectomy. The thoracic surgeon should be able to perform his own bronchoscopies and to decide for himself the question of operability.⁴ The presence or absence of carinal fixation, the distance of the visualized neoplasm from the carina, and the presence of proximal submucosal extension, are all important factors in making a decision.

Of considerable benefit from the operative standpoint is the great subjective improvement which often follows bronchoscopy. If the neoplasm causes obstruction, it has been our practice carefully to remove obstructing tissue, dilate the bronchus, and aspirate all secretions. The decreased cough and sputum, loss of fever, and improvement in appetite are valuable aids in the preparation of a patient for operation.

Other less frequently used methods of diagnosis in early bronchiogenic carcinoma may be summarized briefly. None of these, however, should replace roentgenographic study or bronchoscopy. Dudgeon⁵ has perfected a "wet-film" technique for the study of neoplastic fragments in fresh sputum. Transthoracic aspiration biopsy in peripheral neoplasms has been employed by Craver and Binkley⁶ with success. But the indiscriminate use of this method is not justified because of the dangers of infection and of implantation metastasis. The verification of peripheral neoplasms also may be obtained by thoracoscopic inspection following induction of pneumothorax. Bronchograms which show bronchial defects on repeated examinations may be of value.

AUTHORS' SERIES

Six total pneumonectomies for primary carcinoma of the lung have been performed by the writers, with postoperative recovery in four patients. In neither fatal case was death due to opera-

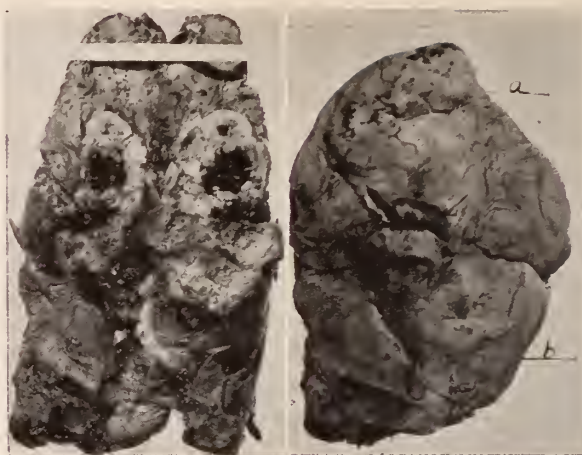


Fig. 6.—Right lung. Operative specimen from Case 6. (A) Outer surface: (a) upper lobe; (b) middle lobe. Arrows point to the carcinoma which arises in the upper lobe, but which encroaches on both main and accessory fissures. This specimen demonstrates the futility of attempting lobectomy even in cases of peripherally-situated carcinomas. (B) Longitudinal section. The central portion of the carcinoma became necrotic and has excavated (see Fig. 4).

tive shock. These two patients survived eleven and twenty-four days, with death resulting from purulent pericarditis and empyema, respectively. It is of interest that in both fatal cases the pneumonectomy was right-sided. It is our impression that adequate closure of the stem bronchus is more difficult on the right, due to the relatively higher origin of the right upper lobar bronchus. In addition, mediastinal shift to the right, and compensatory hypertrophy of the left lung, do not take place as easily as do the corresponding mechanisms for obliteration of the left pleural cavity.

A summary of the six cases follows. Details of the histories and operative technique have been presented elsewhere.⁷

REPORT OF CASES

CASE 1.—A white male, aged 62, complained of productive cough, weakness, and loss of weight for a period of three months. Roentgenograms showed atelectasis of the left upper lobe. Bronchoscopy showed occlusion of the left upper lobar bronchus, as though from external pressure. No biopsy was procured. Pneumonectomy was performed by mass ligation and the pleural cavity was drained. Bronchiogenic carcinoma was verified microscopically. The patient died suddenly from coronary thrombosis one year following operation. There was no evidence of recurrence. He had been working for many months prior to his death.

CASE 2.—A white male of 63 years had a five months' history of recurring fever, pleurisy, productive cough, and blood-streaking. The original diagnosis was pneumonia. Roentgenograms showed a wedge-shaped infiltration of the left lower lobe. Bronchoscopic biopsy was confirmatory of primary carcinoma of the lung. Pneumonectomy was performed and the patient made an uneventful recovery.

CASE 3.—A white male of 36 years had a nine months' history of paroxysmal productive cough, blood-streaking, wheezing, weakness, and loss of weight. Roentgenograms showed a dense, rounded mass in the left lower lobe. The diagnosis was confirmed bronchoscopically. Pneumonectomy was performed successfully. The hilar lymph nodes showed metastases. The patient was relatively well for

four months, but died eight months after operation with symptoms of cerebral metastases.

CASE 4.—A white female of 32 years had a six weeks' history of nonproductive cough and slight loss of weight. Initially, there was severe left-sided pleurisy. Roentgenograms showed a small rounded mass in the left lower lobe. No tumor was visualized bronchoscopically. "Blind biopsy" with cup forceps and curette, however, was productive of neoplastic tissue. Pneumonectomy was performed successfully. Later, rib resection was necessary for a localized empyema. Convalescence is progressing, although thoracoplasty may be necessary because of persistent left-sided thoracic pain.

CASE 5.—A white male of 54 developed a "cold," which did not subside. There was an eight months' history of productive cough, with blood-streaking, night sweats, loss of weight, and pain in the right upper thorax. Roentgenograms showed atelectasis of the right upper lobe, and bronchoscopy confirmed the presence of a neoplasm blocking the upper lobar bronchus. During pneumonectomy the pleural cavity was grossly contaminated. Intercoastal drainage was provided. Following an initial period of recovery, the patient died suddenly on the eleventh post-operative day. At autopsy, an acute purulent pericarditis was discovered.

CASE 6.—Seven months prior to operation a white female of 61 years began bringing up, almost without effort, blood-streaked purulent material. The onset was insidious. Slight cough later developed, with associated ease of fatigue and loss of weight. There had been a long-standing history of asthma. Roentgenograms showed a large, irregular cavity with greatly thickened walls lying peripherally in the right upper lobe. The white blood count was 11,300. Bronchoscopy did not reveal neoplasm. In the differential diagnosis, pulmonary abscess was ruled out because the patient was not ill enough, and because the roentgenograms were not characteristic. The lung was removed and on section a carcinoma with necrotic center was found (Fig. 6). Putrid empyema developed and the patient died twenty-four days following pneumonectomy.

SUMMARY AND CONCLUSIONS

At present any expectation for cure in primary cancer of the lung lies with radical resection, preferably by pneumonectomy. In the seven years which have elapsed since Graham's first successfully removed a lung for carcinoma, great strides have been made in reducing the operative mortality. Several patients already have survived total pneumonectomy for five years or longer without evidence of recurrence.

As with carcinoma elsewhere in the body, early diagnosis is paramount if surgery is to be effective. With this thought in mind we have detailed the various early symptoms which should suggest the possibility of bronchiogenic cancer. We wish to emphasize again that thorough roentgen studies and bronchoscopy are invaluable procedures in establishing a diagnosis.

Brief histories have been given of six patients who underwent total pneumonectomy. In this group, four patients recovered from operation.

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IMMEDIATE MANAGEMENT OF SURFACE INJURIES*

By GERALD BROWN O'CONNOR, M. D.
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TO avoid repetition and to give a clearer concept of the immediate management of surface injuries, I have elected to divide the treatment into (1) general considerations and (2) specific procedures directed to certain local areas.

The optimum time to see and start appropriate treatment for any surface injury is as soon as possible after the injury has occurred. This is elementary, and should be a foregone conclusion with men handling these cases; but too often there are instances where hours of delay have intervened through no fault of the patient, the injury being attended to at the convenience of the attending surgeon. Every moment's delay jeopardizes the possibility of a good end-result and, naturally, increases the incident of infection. Perforations of the body covering should be given the same prompt attention that the surgeon knows, from experience, he must give perforations of the viscera. The longer the delay the more likely are complications.

If the injury is of any import, it should not be looked on as an office procedure, but the patient should be given all the advantages of the modern hospital. This is such a well-known fact that experienced insurance companies will insist that hospital entry be effected immediately after they have been notified.

Primary hemorrhage occurring as the result of the injury must be stopped, and shock should be combated to the fullest extent to improve the patient's general condition as well as to speed local healing.

CHOICE OF ANESTHETIC

The choice of the necessary anesthesia lies with the attending surgeon. I prefer local (1 per cent novocain) as a block or distal infiltration anesthesia where possible; otherwise, gas or ether inhalation, as indicated. For extensive hand injuries involving tendons or nerves, gas anesthesia is satisfactory.

* Read before the Section on General Surgery at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.



Fig. 1a

Fig. 1b

Fig. 1a.—Lacerated forehead due to glass. Frontal bone exposed for three inches under scalp.

Fig. 1b.—Primary repair under block anesthesia. Wound completely healed in seven days.

PREPARATION OF FIELD OF INJURY

The preparation of the field surrounding the injured areas should be just as complete and efficient as if one were proceeding with a clean surgical case. Shave, if necessary, then clean with soap and water, and paint with either tincture or the aqueous solution of merthiolate. The wound is thoroughly investigated and then irrigated with normal saline solution that completely floods the wound, but is not forced in under pressure. I then saturate the wound with the tincture or the aqueous solution of merthiolate. This type of antiseptic is, of course, my personal preference.

A complete debridement is done, sacrificing any damaged or traumatized tissue, which will only act as a pabulum for bacteria. This devitalized tissue makes wonderful culture media and will change a clean wound into a septic one. A thorough debridement is one of the most important steps in effecting a clean wound with resultant primary healing. Then an accurate reposition of all the injured tissues to their respective, normal positions, with a minimum of suture material is accomplished. The wounds are then inspected and complete hemostasis established. Hematomata mitigate against clean wounds and primary healing. The skin covering should then be closed without drainage, except in rare instances. The sutures should not be placed under tension and should allow for the resultant edema that occurs. An accurate splinting of the part will do much to relieve tension and promote primary healing.

In dealing with all surface injuries, unless decidedly contraindicated, I effect an immediate epithelial covering for all denuded areas. This is *sine quo non* in reconstruction surgery. A traumatic technique is a necessary prerequisite in all of this work if one is to obtain the most satisfactory primary healing and better end-results. This technique is complex, but, generally speaking, it is the meticulous attention to the many small details that negates trauma. In addition to the above suggestions, certain areas require more specific treatment to bring about primary closure.

I routinely give my patients the prophylactic dose of tetanus antitoxin, and never hesitate to give large doses of gas-gangrene antitoxin whenever it is indicated.



Fig. 2a

Fig. 2b

Fig. 2a.—Complete laceration of tip of nose by auto glass. Septal and alar cartilages exposed and mucosa severed.

Fig. 2b.—Result of primary repair of all nose elements under local anesthesia. It was unnecessary to do any additional reconstruction after primary repair.

SPECIAL AREAS

Scalp.

Sutures should go completely through the scalp at right angles to the incision one-quarter inch from edge. Pressure dressings should be applied to prevent hematoma. If part of cranium is exposed, the bone should be covered with the adjacent scalp, or one may have to create a flap to cover the denuded bone to prevent a sequestrum and place a skin graft in the donor area. When this procedure is carried out the pericranium should be preserved in the donor area.

Ear.

All cartilage should be covered if exposed. Hematoma must be drained and the collapsed skin and perichondrium held snug against the cartilage. This can be done, after the hematoma is evacuated, with plaster of Paris inlaid into the ear convolutions, and dependent drainage is established. One can do an immediate repair from adjacent skin or bury the severed part of the ear under the scalp and use it for reconstruction later. Severed ear flaps with small pedicles, if properly sutured and not choked, do surprisingly well even though there is some question of their viability immediately following an accident. Lacerations into the external canal should be accurately reconstructed and continual dilatation should be effected. If necessary an immediate skin graft, split or Thiersch, should be done to cover any defect; otherwise a very troublesome stenosis will result. This is especially true if the lacerations extend around the circumference of the cartilaginous canal.

Eyelids.

To prevent any corneal damage, or a resultant extropion or entropion, accurate reposition of all lid elements must be effected. If the center portion of the upper lid is lost, immediate replacement with a lining and covering must be done, to give the cornea its necessary protection. One must remember that the lining must be smooth, non-irritating, and any sutures that are used must not lie in contact with the cornea.



Fig. 3a

Fig. 3b

Fig. 3a.—Complete laceration of nose, lip and palate, due to explosion of emery wheel. Multiple, comminuted fracture of nasal bones, septum and maxillae. Repaired under local block anesthesia. Hospital stay five days.

Fig. 3b.—Results of primary repair. Healing occurred by first intention. Returned to work two and one-half weeks after original injury.

Nose.

So often fractures of the nose are not attended to or passed over until marked deformity is noticed after the swelling has subsided. Fractures of the nasal framework can be readily reduced early to give a good functioning and cosmetic effect. If the fracture is unrecognized they become more difficult to reduce as time progresses, considerable manipulation being required as early as the second week. The majority of these fractures are directly depressed or distorted to right or left. This involves the nasal bones, nasal processes of maxillae, and septum.

A simple system of handling these cases under (1) sodium pentobarbital anesthesia, (2) local (1 per cent novocain) anesthesia, (3) gas and oxygen anesthesia, is:

1. Elevation of nasal bones and fractured septum.
2. Reduction of the fractured nasal processes of maxillae, inward or outward, as indicated.
3. Digital molding to center the nose.
4. Placing of one soft-rubber tube and one cigarette drain in each nostril.
5. Application of a molded external nasal splint of blocked tin.

Lacerations completely through the nose require both internal and external sutures to close the lining as well as covering to prevent webbing and stenosis.

Face.

In facial injuries an accurate early reposition of the fractured bones is essential to get normal contour. If unattended, marked distortion usually occurs that necessitates refracture and/or the use of refrigerated cartilage grafts to restore normal contour. Suture of facial muscles and severed nerves should be accomplished at the primary procedure to restore normal muscle tone and give the nerves their best chance to regenerate. This regeneration will occur if the severed nerve ends are



Fig. 4a

Fig. 4b

Fig. 4a.—Severance and avulsion of extension tendon of ring and little finger. Repaired under tourniquet and gas anesthesia.

Fig. 4b.—Complete extension of ring and little finger following extensor tendon suture. Fingers splinted in hyperextension for five weeks following tendon suture.

accurately sutured early. The paralyzed facial muscles should be properly splinted to protect any elongation of the muscles until nerve regeneration has taken place and normal muscle tone has returned. It is needless to say that maxillary and mandibular fractures should be accurately reduced in good anatomic position to get the best eventual functional and cosmetic result with a satisfactory dental occlusion.

Mouth.

I am firmly of the opinion that lacerations of the buccal mucosa should be given the same immediate care as lacerations of the skin. Suture should be done, and for this, in small children, I use catgut and in adults, horsehair or silk. In tying the sutures it is important to place at least three knots in them; otherwise, due to motion and moisture, they may come untied. These sutures should not be tied tight, but just approximated, otherwise they will cut through when the post-traumatic edema occurs.

Hands.

All hand injuries in which tendons or nerves are severed should be looked on as a major surgical procedure, and the patient sent to the hospital, where the repair should be effected immediately in a bloodless field, preferably under gas anesthesia.

Generally speaking, primary suture of tendons and nerves should be done up to six to eight hours after injury, in a relatively clean field. Delayed repair should be done in all badly contaminated wounds, and when the six- to eight-hour time limit has passed. Openings into the smaller joints of the hand can also be handled in the same manner.

Adequate splinting of injured tendons or nerves, of course, is essential for their proper repair.

If the covering of the hand, particularly the dorsum, is avulsed after the usual careful surgical toilet, suture of the wound is done with the proximal sutures left relaxed for twenty-four hours to permit the edema to subside. If the covering flap is immediately sutured tight, the resultant edema may lead to considerable covering loss.

Any skin losses that will leave a denuded area should be grafted immediately, preferably with Thiersch or split-skin graft. If tendons, joints, bones, or nerves are uncovered, they should be recovered, using skin and subcutaneous tissue as a covering. This may necessitate suture of the digit into the abdominal wall or other satisfactory donor area. Finger stumps can be treated in the same manner. This is done only, of course, in clean wounds in which primary closure of the injured area would be considered.

Lower Extremities.

All lower-leg denuded areas should be covered with epithelium during the primary surgery. This includes compound fractures unless strongly contraindicated. The surface defect over the bone can be closed by utilizing a double pedicle sliding flap with a split-skin graft to the donor flap area. If these two thoughts are kept firmly in mind, compound fractures will be converted into simple fractures, and lower-leg ulcers that are so resistant to treatment will be very materially reduced.

490 Post Street.

THE INTERPRETATION OF LABORATORY EXAMINATIONS IN THE DIAGNOSIS OF INFECTIOUS DISEASES*

By CHESTER S. KEEFER, M. D.

Boston, Massachusetts

PART III†

OCCASIONALLY in communities where rickettsial diseases are not common, one encounters a patient who has the clinical picture and course of typhus fever. Perhaps the commonest rickettsial fever in the United States at the present time is the eastern and western variety of Rocky Mountain spotted fever, both caused by the same types of rickettsia. Sporadic cases of this disease have been reported in Massachusetts recently and I have had an opportunity within the last two years of observing a patient who had typical typhus fever, which was acquired while working in a laboratory where experiments were being carried out on typhus fever. The clinical course and laboratory examinations in this particular case were instructive.

A young man with fever and leukopenia develops rash and positive Weil-Felix reaction.

CASE 7.—A young man, 26 years of age, working as a laboratory technician handling animals, had been inoculated with rickettsia and for typhus fever. He had used every known precaution against these infections, but two days before admission he had a sudden departure from health with fever, malaise, headache and prostration. On the second day of his illness he had a chill and his temperature rose to 101.8 degrees Fahrenheit; and on the third day of his illness his temperature was 103 degrees Fahrenheit.

* From the Thorndike Memorial Laboratory, Second and Fourth Medical Services (Harvard), Boston City Hospital, and the Department of Medicine, Harvard Medical School, Boston.

Read before the General Medicine Section of the California Medical Association at the sixty-eighth annual session, Del Monte, May 1-4, 1939.

† Part I of this paper appeared in CALIFORNIA AND WESTERN MEDICINE, September, page 111; Part II, October, page 173. Owing to the extra space needed in this issue for presentation of Medical Preparedness information, the concluding portion of Dr. Chester S. Keefer's article will now appear in two sections: Part III in current November issue, and Part IV in the December number.

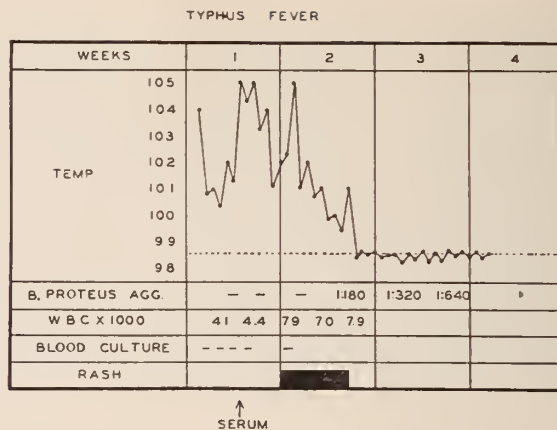


Fig. 4.—(Case 7) Chart showing temperature curve and results of laboratory examinations in a case of typhus fever.

He complained of some photophobia and injection of his conjunctivae. He experienced some abdominal pain but, aside from that, had no complaints.

Physical examination showed a young man who was mentally clear but obviously acutely ill. There was marked injection of the conjunctivae, both palpebral and bulbar. His neck was not stiff and there was no deafness. Heart and lungs were clear. The tip of the spleen was just palpable and there was no cutaneous rash. Laboratory examination showed that the red blood cell count was 4,610,000, hemoglobin 98 per cent, and white blood cell count 4,100. Blood culture on admission was negative as were the agglutination tests for Proteus OX19, typhoid, paratyphoid and B. melitensis.

The course of the disease is recorded in Fig. 4. In view of the negative blood culture, the leukopenia, and the history of exposure to typhus, on the third day of his illness he was given 40 cubic centimeters of antityphus serum (Zinsser). Temperature remained high in spite of the serum and a rash was completely absent until the ninth day of his illness, when a diffuse macular eruption appeared over the trunk, abdomen and extremities. The temperature returned to normal on the fifteenth day of the illness and, at that time, the Weil-Felix reaction against Proteus OX19 was positive in a dilution of 1:160. This gradually increased so that the titre in his blood serum on the twenty-third day of illness was 1:640.

In this patient the rash did not appear until the ninth day of illness, and the Weil-Felix reaction was not positive until the day the temperature returned to normal. The history of exposure to typhus, the high fever, leukopenia, negative blood cultures, and negative agglutination reaction to the enteric group of organisms forced the conclusion that the patient had typhus fever before the rash or the positive agglutination reaction appeared.

From previous experience with a large number of cases of typhus fever in the Orient, I observed that the Weil-Felix reaction is usually negative during the first week and becomes positive in increasing numbers of cases during the second week. Between the second and third week it is usually positive in 100 per cent of the cases examined. It commonly falls off after the fourth week from the onset of the illness. The average titre of the agglutinins varies from 1:320 to 1:1280, the extremes being, in my experience, 1:80 and 1:5120. Since the titre usually increases during the second week, repeated examinations at this time are of great value to diagnosis. This may be especially important in the individuals who show both a positive agglutination reaction to the Proteus OX19 and to the typhoid

bacillus. When agglutinins are present for both these groups of organisms the interpretation may be exceedingly difficult since the clinical picture may, in many respects, be similar. When this problem arises, simultaneous agglutination tests should be made with both groups of organisms repeatedly, and the variation in the titre of both noted. Usually, if one is dealing with a case of typhus fever, the *Proteus* OX19 organism is agglutinated in increasingly higher titre as the agglutinins for the typhoid bacillus remain more or less stationary.

(To be continued)

LURE OF MEDICAL HISTORY

UNITED STATES ARMY FIELD HOSPITAL IN SAN FRANCISCO IN 1906*

AN INTERESTING LETTER: WITH SOME EXCERPTS
FROM THE MAY, 1906, ISSUE OF THE CALIFORNIA
STATE JOURNAL OF MEDICINE

AFTER years of friendship between men it sometimes happens that certain events in which either has had an experience may never come up in conversation with one another. Recently, for example, William Thornwall Davis, M. D., of Washington, D. C., now professor of ophthalmology in George Washington University in that city, and with whom the writer, in 1912, spent many interesting hours in the eye clinics of the University of Vienna, on a brief visit to San Francisco called at the editorial offices of the California Medical Association. Recounting some reminiscences, it came to light that Doctor Davis, who in earlier years was in the medical corps of the United States Army (a major of the regulars), had also been assigned to special duty at the time of the great disaster that overwhelmed San Francisco in the early morning of April 18, 1906.

Doctor Davis' new and interesting story led the editor to exact from him a promise to outline in a brief letter the high points of the narrative, believing that such a communication would be a distinct addition to the State Medical Association's archives.

On his return to Washington, Doctor Davis kept his promise, as may be noted in the letter which follows:

(COPY)

927 Seventeenth Street, N. W.
Washington, D. C.
September 28, 1940

George H. Kress, M. D.
450 Sutter Street
San Francisco, California

Dear George:

The following is a brief account of the field hospital at the Golden Gate hospital in 1906. You can dress it up as much as you like.

* By George H. Kress, M. D., San Francisco, editor of CALIFORNIA AND WESTERN MEDICINE.

I had only just arrived in Washington by way of New York from the Far East, having traveled through China, Sumatra, Sudan, India, Egypt, and Europe over a period of a year. Twenty-four hours after I arrived in Washington, news came of the disaster in San Francisco. A special train was immediately organized with a full hospital corps company and we started straight across the continent, nonstop, except to change engines. We started with six coaches and two or three baggage cars. Clear across the continent, citizens were building bonfires in the middle of the track to add one or more cars of supplies. We picked up twenty-five white Red Cross nurses in Chicago. When we arrived in San Francisco we had a train a mile long. All sorts of supplies and provisions were taken on at the different towns through which we passed. There were about two hundred nurses and a number of doctors who climbed on board and stayed there.

The fires were still burning and they were dynamiting houses on the hills when we landed at the ferry in San Francisco.

We marched up Market Street between the smoldering ruins, out to the Golden Gate Park and put up our field hospital, under canvas. You can picture the scenes of the people who had been wealthy and in luxury the day before, sleeping with only a blanket on the ground or nothing. We had some few wounded and sick; we had asked for and obtained permission to take as many in the hospital for care as we could. This was done to the great benefit of many wealthy people who had escaped from their palatial homes just the night before. I found a number of my friends whom I had known when I was stationed at the Presidio, who had been lovely to me, and it was a source of greatest gratification to help them in their time of great need.

I received on that trip an object lesson that I shall never forget; the generosity of the American people and their resiliency in time of trouble, of their ability to come back after losing all and immediately rebound to a happy frame of mind. They sat about the campfires in the Park and sang and joked and talked as if they were on an outing, and as soon as the embers had cooled they were back on the job with great energy to build the great city of today.

The unselfishness of the people at that time, their courage and their fortitude, is something that I shall never forget. Don't ever let anyone tell you that the American people are not courageous and generous or that they have become soft. That is not so.

If you find you want any more details, I will give them to you, but these are all the bare facts which I told you I would send you.

Very sincerely,

Wm. Thornwall Davis, M. D.

✓ ✓ ✓

SOME EXCERPTS FROM THE OFFICIAL JOURNAL

Members of the California Medical Association who have come to the State since 1906, and who have not had occasion to look into the history of those memorable days, may also be interested to learn that the annual session of the State Medical Association convened at San Francisco on Tues-

day morning, the 17th of April, on the day before the earthquake, when the meeting was held in the old Y. M. C. A. building, located then on Mason and Ellis streets.

For readers who may wish to know more concerning those days, it may be stated that bound volumes of the official journal—*California State Journal of Medicine*, as CALIFORNIA AND WESTERN MEDICINE was then called—may be consulted in the medical libraries at the University of California, Stanford University, and the Los Angeles County Medical Association.

The annual session program of the year 1906 was printed on page 117 of the April issue of the *State Journal*, that number having text pages 113-150, inclusive.

But the May, 1906, issue was only a four-page issue! Read what Editor Philip Mills Jones, founder of the OFFICIAL JOURNAL, wrote at that time:

* * *

A SAD GREETING

"It was a very different sort of May issue we had planned. But as all the world now knows our beautiful city of San Francisco has been wiped out of existence. The editor has been able to confer with but one member of the Publication Committee and a few of the delegates living in Oakland, and these have authorized the bringing out of this number in its present form. There is not a business house of any sort left standing in San Francisco—no paper house and no printer—so this number is printed in Oakland. The mailing list of the *Journal* has also vanished, so that many exchanges and subscribers will not at once receive this issue. However, enough copies will be printed to supply all regular recipients in the course of time. We would respectfully request other journals to copy this statement and also say that no sample copies will be sent out. The present address of the *Journal*, or rather of the editor, for the *Journal* office is beneath the editorial hat, which was almost his only possession not destroyed, is 1230 Telegraph Avenue, care of Dr. Frank Adams, Oakland, California. Correspondents are respectfully warned, however, that their letters may not be answered immediately, for almost all typewriters have been destroyed and the whereabouts of our stenographer is an unknown quantity."

* * *

FUTURE ISSUES

"We desire to get out this May issue in its sadly abbreviated shape in order to let all whom it may concern know that while we are now sitting on the ashes of our former property and have nothing but a pencil, a piece of paper and some credit, the spirit of the physicians of California is in nowise daunted. When the *Journal* was born we were told that it could not live; but it thrived and waxed lusty. Shall we allow the 'devil with two sticks' to do what human scheming could not do—stop us? Hardly! As there will be a newer and a better and more beautiful San Francisco, so there will rise, Phoenix-like, we trust, a better and a more useful *California*

State Journal of Medicine. But we must needs ask your patience, for our troubles are mighty, and while they do not crush us, they weigh heavily. The June number will not be issued until it can come out in regular size and garb."

* * *

SEMICENTENNIAL MEETING

"Undoubtedly the annual meeting of the Medical Society of the State of California for 1906—its semicentennial—will remain forever the one most generally remembered. The registration book, unfortunately, is not at hand—one can only say that it once existed—but it is known that about 4 p. m. on Tuesday, April 17, the first day of the session, nearly three hundred members had registered. The program was unusually good; at least one copy is known to exist, and there may be others. The general session in the morning was well attended, the principal subject of interest being the report of the various members of the Board of Examiners. It seemed apparent that the administration of the present law was working satisfactorily in improving the standards of medical schools and in keeping out poorly qualified graduates.

"In the afternoon four sections were in session: Surgery, Medicine, Urology and Dermatology, and Eye, Ear, Nose, and Throat. The full programs in these sections nicely filled out the afternoon. In the evening the House of Delegates met and devoted its time to hearing reports and to a considerable discussion of the fee for insurance (life, not fire) examinations. The minutes of this session, together with the reports handed in, are not destroyed, but are somewhere near the Cliff House, and eventually will be published.

"Everything promised an unusually harmonious and profitable meeting. Unfortunately, our plans were not well adapted to those of the remainder of the universe. At 5:14:48 on the morning of the 18th, the city was wrecked by an earthquake which lasted but forty-eight seconds. This, to those in other places, is now but ancient history, but to those of us who went through that and all the following days of horror, it will never become ancient. Fire broke out in unnumbered places immediately after the shock, and as nearly all the water supply mains had been broken, what the shock began the fire completed.

"Shortly after 9:30 a. m. on Wednesday, the president, Dr. R. F. Rooney, the secretary, Dr. Philip Mills Jones, and Drs. James H. Parkinson and H. Bert. Ellis gathered on the steps of the wrecked Y. M. C. A. building and declared the Society adjourned *sine die*. The Secretary made three trips to the office, on the third floor, and saved the account books, minutes of the Council, and minutes of the House of Delegates, together with some miscellaneous papers hastily gathered together. All advertising contracts, current vouchers, etc., are in a safe deposit vault, perfectly intact. When or where the next meeting of the Society will be held, no one knows; probably a meeting of the delegates will be called in due time. Even the whereabouts of the president, Doctor Rooney, are unknown to the secretary.

"Some buildings were burning fiercely within fifteen minutes after the shock, and within twelve hours one-half the city was a solid mass of fire. So fast did it spread that the fire raged as fiercely, seemingly, for blocks behind the fire line as it did immediately in the zone of devastation. In places it spread so fast that those escaping were caught and had to abandon the few effects they were endeavoring to remove. In the streets on the hills, which were considered safe, whole trainloads of personal effects and household goods were burned.

"It is in considering the small personal things that the absoluteness of destruction makes itself felt. One's bunch of keys, for instance. The office-building key—throw it away, the building is no more, and so the office key, and the desk, and the office closet. Next comes the house-door key—it, too, is useless, as well as the trunk keys. The club keys, too, can go, for the clubs are gone already. Shall I telephone? There is no such thing! Would I have a glass of water? In more than four-fifths of the city there is not a drop. On every side there is nothing but burned ruin and torn and twisted streets. Yet already are plans for rebuilding made; tracks for removing debris are laid into the heart of the ruins, and later, materials for the construction of a new heart of a new San Francisco will be brought in on them."

To those physicians of California, however, who were in San Francisco on April 17 and the days that followed, the stories given in the recent letter of Dr. William Thornwall Davis, and the excerpts taken from the four-page *Official Journal* issue of May, 1906, should bring back the vivid memories.

For instance, the writer still visualizes the group of physicians from cities in the southern part of the State, who on Tuesday morning, the 18th of April, about the hour of nine o'clock, gathered in Union Square Park, opposite the Hotel St. Francis, debating what to do next. It was agreed that it would be wise to lay in a stock of provisions and then go out and set up camp in Golden Gate Park. Dr. John C. King of Banning (who became president of the California Medical Association in 1910 and who is now the ranking senior ex-president, residing in Pasadena) volunteered to hire a wagon and lay in a supply of food. While he was engaged in this search, most of the group (among others the late Dr. Fitch C. E. Mattison of Pasadena, who became president in 1913) were seated at the base of the Victory Monument in the Park. The dash for open spaces when some secondary tremors caused the tall column to begin to sway is a picture not soon to be forgotten.

Mention may also be made of the fact that, on Tuesday afternoon, April 17, many members of the State Medical Association—of whom the writer was one—were seated in the auditorium of the old Y. M. C. A. on Mason Street. In the room where those meetings were being held, on the fateful morning of the 18th the roof fell in. Had the earth's tremors occurred on Tuesday afternoon, when the auditorium was crowded with physicians, instead of at five o'clock the next morning, a large

number of physicians would undoubtedly have been killed, and the pages of the history of medicine in California during the next two or three decades would have presented other names than now appear on the rolls.

* * *

In concluding these comments, it may be added that the State Association's Committee on History, which works through the Association office at 450 Sutter Street, San Francisco, will welcome communications, memorabilia, and other information concerning the events of 1906 and other periods.

CLINICAL NOTES AND CASE REPORTS

HEMOCHROMATOSIS

REPORT OF AN EARLY CASE

By MORRILL L. ILSLEY, M. D.
Claremont

THIS case, though the patient died of cardiorenal failure, nevertheless shows many of the typical findings characteristic of the syndrome: hemochromatosis.

REPORT OF CASE

H. B. A., born in 1873, passed away on July 27, 1939, of chronic myocarditis, chronic nephritis; mitral insufficiency being a contributory cause.

The patient was not at all clear about his early history. He remembered that in 1898 he had a very severe case of typhoid fever. He was ill for six weeks with this disease. He may have had scarlet fever. He had the usual childhood diseases. He had a very severe attack of influenza in 1897, and since that time he has had many subacute attacks. He remembered having had a very thorough examination in Lincoln, Nebraska, twenty years ago, and the physician stated that he had a normal heart at that time. He had sinus trouble for years. There have been no accidents. There was no surgery. No lung trouble (I asked him this specifically, since his wife is a tuberculous patient.) There has been no gastro-intestinal trouble; no genito-urinary trouble. No joint trouble. His extremities have been cold and the circulation impaired for at least ten years.

History.—The following is an account of the patient's troubles since I have been caring for him. This has been very occasionally, due to his propensity for seeking chiropractic aid. I first saw him on May 6, 1934, at which time he had frequent stools, no blood, generalized headache. He was then under treatment from Doctor McBurney of Pomona for sinus involvement. He had no complaints of heart or lung trouble. Nocturia one time. He stated that there has been trouble with his toes since 1930; he could not control them and they felt cold all the time; there was a form of anesthesia. There were frequent internal pains in the right hip. There was itching in the groin for a long period of time. At Scripps Metabolic Clinic he had an examination in 1933, at which time they gave him a very grave prognosis from a circulatory standpoint. The pigment was present on the anterior portion of the legs even then, but I did not recognize its significance.

I saw him again on February 21, 1935, at which time he had an acute respiratory trouble, with a rise in temperature of 101 degrees.

On March 30, 1938, I was called to see him because of repeated attacks of "influenza." At this time he had Vincent's angina. Cheyne-Stokes respiration was also bothering severely at the time. He was troubled with spells of weakness and had a great deal of intestinal gas. He had been having spells of diarrhea every eight or ten days. He complained of malaise and "inner collapse" at this time.

He stated that he had what he called migratory neuralgia in the foot, ankle, knee, elbow, head, back, and fingers. He had pain down his left arm during this attack of "influenza." He had been having edema of the ankles, with night sweats. Dyspnea was present, also orthopnea for the past several years. Nocturia two times during this period. He had lost 15 pounds since January. He had taken no exercise during the past year. Weight then was 162¾ pounds; height, 70 inches; blood pressure, 158/126. The eyes were bulging at this time, giving the appearance of a hyperthyroid case. The urine showed three plus albumin. Two blood chemistry determinations had been made as follows:

	Mar. 14, '38 (mgm.)	Apr. 27, '39 (mgm.)
Creatinin	1.37	1.8
Urea nitrogen	27.9	26.8
Nonprotein nitrogen.....	40.0	39.9
Sugar	104.8	

The electrocardiogram, taken on March 30, 1938, showed tachycardia, left axis deviation, a PR interval of 0.20 second, a QRS interval of 0.10 second, notching of QRS segment in all four leads.

Subsequent Course.—On April 1, 1938, the patient had a right atrium infection. His white blood count was 9,200; red blood count, 5,900,000; hemoglobin (Sahli), 84 per cent; blood pressure, 156/122. The pulse rate on April 11 was 108, with no rise in temperature. The liver margin was not below the costal margin at that time. The loud systolic murmur, which was present at least as long as I had been seeing him, persisted during the entire course of the illness. On June 4, 1938, he had another attack of nausea and vomiting. On September 24, 1938, he noticed impaired circulation below the knees. There was no edema present and no urinary symptoms. Night sweats bothered occasionally at this time; nocturia one time. Weight, 148¾; blood pressure, 144/98. On October 22, 1938, the patient had an attack of coryza. From that time until his death the bowel complaint ceased, excepting for a slight reappearance, on November 9. At this time he complained of precordial distress, and this was the only time I was able to persuade the patient to go to bed during his entire illness: he became so ill in June, 1939, that he finally consented. There was a most persistent nosebleed in November. On February 14, 1939, his weight was 146½. At this time he had a headache in the frontal sinus region. There was very definite distress in the right ankle joint. There was an irregularity in the pulse rhythm at this time. With the help of colchicin, an attack of gout in the left great toe was aborted in March, 1939: this attack was probably due to the use of xanthin derivatives in treatment. The course of the disease from June, 1939, was typical of a failing cardiorenal system. Cheyne-Stokes respiration was constantly present, and intravenous injections of aminophyllin failed to break the cycle. It was about June 26, 1939, that I first considered that hemochromatosis complicated the case. His liver margin could be felt below the costal margin since March, 1939. The pigment was noticed around the nail beds, and also extending from the hands up to the midportion of the forearms; in this region the pigment was not discrete. On the legs there were numerous spots of this same rusty iron-hued pigment. The urine, however, never showed the slightest trace of sugar; however, the presence of albumin and casts constantly increased in amount as the case progressed. As stated, the patient died on July 27, 1939.

Autopsy Findings.—The autopsy was performed by Dr. L. W. Case of Pomona. The gross findings were as follows: Edema was generalized, but especially noticeable in the extremities. The liver weighed 1530 grams. The cecum and bladder were both attached to the abdominal wall with dense adhesions, and Doctor Case thought he must have had serious trouble with his appendix at some time. The stomach was moderately distended with fluid. The bladder was somewhat distended with urine. The left lateral lobe of the prostate was definitely enlarged. The scrotum was edematous. The right kidney weighed 200 grams and the left, 220 grams; both were abnormal. The spleen weighed 205 grams. The right lung weighed 555 grams, and showed red hepatization of the lower lobe. The left lung weighed 450 grams, and it, too, showed red hepatization of the lower lobe (the left was more advanced). The heart weighed

640 grams; the tricuspid valves were normal; there was marked atheroma of the aorta; the mitral valve was badly thickened with white scarred tissue; there was hypertrophy of the left heart. There was no fluid in the pericardial sac. The coronaries were not excessively sclerotic. The skin showed the peculiar rusty iron pigment previously described, and this was particularly distributed on the forearms and legs. It was interesting to see the half-moon-shaped distribution about each nail bed of the hands. Doctor Case reports the microscopical findings as follows: Microscopic study of sections of the liver shows a rather diffuse necrosis of the liver cells especially noticeable about the efferent veins of the lobules. There is an irregular infiltration of the tissue with small lymphoid cells, but no evidence of active inflammatory reaction. There is only slight increase in the amount of fibrous connective tissue, the amount not being enough to give a picture of true cirrhosis. Sections of the kidneys reveal moderate sclerosis of the larger blood vessels, and thickening of the walls of the arterioles, and of the capillary basement membrane of the glomerular tufts. There is also some thickening of Bowman's capsule. There is a diffuse cloudy swelling and moderate desquamation of the tubular epithelium, and an irregular infiltration of small, lymphoid cells. Sections of the liver and kidneys stained with potassium ferrocyanide solution show the presence of a small amount of hemosiderin pigment irregularly scattered throughout the tissue.

COMMENT

In a personal communication from Dr. Charles A. Doan, he states: "In so far as I know, the finding of hemosiderin in cells other than the Kupfer or comparable cells of the so-called reticulo-endothelial system represents a true pathologic finding. Of course, we now believe that the connective tissue phagocytic cells, normally as well as pathologically, phagocytize red blood cells and break them down into hemosiderin and hemotoidin: the former to be conserved with its iron content for the resynthesis of new hemoglobin, the latter making up the bile pigments. Therefore, the finding of hemosiderin pigment scattered in liver and kidneys within the parenchymatous cells, and not just in macrophages, would be, I should feel, sufficient evidence for establishing a presumptive diagnosis of early hemochromatosis."

1111 Indian Hill.

Unsung Guardians of the Nation's Health.—From the moment when we urban dwellers take in our bottles of milk, through every single activity of the day and even when we sleep at night, we are being guarded, watched, and protected from danger and disease of which we are quite unaware. That the water on our tables is pure, that our sewer systems function properly, that when we walk on the streets we do not come in contact with communicable diseases, that when we dine at restaurants our food is hygienically prepared and served—all these we take for granted as our inalienable right and are inclined to resent the taxes which go to pay for them. Countless unsung millions of the laboratory have struggled to bring about this happy state of affairs, and countless others are still toiling on our behalf. —Dr. Victor Heiser in *You're the Doctor*.

Hard and Soft Water.—There is no evidence that the hardness or softness of ordinary drinking water has any appreciable influence on arthritis, gall-stones or intestinal disorders, *Hygeia, The Health Magazine* declares in answer to an inquiry.

The use of soft water for the skin may be preferable because it increases the purifying action of soaps, producing lather with less free alkali, and thus protecting the skin against the removal of its natural oils.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

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PHILIP K. GILMAN.....Council Chairman
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OFFICIAL BUSINESS

Concerning the Central Office: Report of Special Committee*

During the last several years the Central Office of the Association has been called upon not only to care for a steadily increasing burden of extra work incident to growth in membership, and institution of new activities such as postgraduate conferences, but has been obliged to meet the demands of much extra service associated with such special problems as compulsory health legislation, the organization of California Physicians' Service, and a Basic Science Law.

The additional executive responsibilities involved in the larger routine and additional extra work which were thrust upon the Central Office, fell upon the shoulders of the Association Secretary-Treasurer and Editor who, in addition to those duties, was also acting director of the Department of Public Relations, secretary of the Committee on Postgraduate Activities, chairman of the Committee on Scientific Work in charge of both the scientific and commercial phases of the annual sessions, and who likewise functioned as the business manager of the official journal, CALIFORNIA AND WESTERN MEDICINE. It should be evident that these multitudinous and yet important tasks were more than one man should have been called upon to carry.

At Coronado the House of Delegates, therefore, instructed the Council to develop and institute plans through which the Association work could be better divided. A spe-

cial committee, consisting of the Council Chairman, the President, and the President-Elect of the Association, was appointed by the Council to work out the details of proposals suggested in discussions within the Council and to put into operation changes that had been agreed upon by the Council.

This Special Committee, with the sanction of the Executive Committee and Council, hopes it has solved its major problems through the appointment of an executive secretary, who will relieve the Association Secretary-Treasurer and Editor of some of the extra duties that have been demanded from him during the last several years.

The newly elected executive secretary, Mr. John Hunton of San Francisco, formerly associated with the Pacific Coast edition of the *Wall Street Journal*, will become the business manager of CALIFORNIA AND WESTERN MEDICINE, will be in charge of all business matters and supervision in the Central Office, will be the director of Public Relations, and act in close relationship with the Committees on Public Policy and Legislation and Public Health Education, and will assume such additional duties as may be delegated to him by the Council.

The Association Secretary-Treasurer will act as secretary to the Council and Executive Committee, as provided in the constitution, will be the editor of the official journal, CALIFORNIA AND WESTERN MEDICINE, will be in charge of the scientific phases of the annual sessions, will act as secretary of the Committee on Postgraduate Activities, will visit county medical societies with other officers, will promote exhibits at state and county fairs, will compile material for a history of the medical profession of California, and will perform such other duties as may be delegated to him by the Council and Executive Committee.

The arrangements indicated above have been made to the mutual satisfaction of all concerned and without any increase in expense to the Association. The executive secretary, Mr. John Hunton, assumed his duties on October 1.

The Special Committee in charge of these changes submits the above for the information of the component county societies and members, and bespeaks for the Association secretary-treasurer and editor, Dr. George H. Kress, and the newly appointed executive secretary, Mr. John Hunton, continued and generous coöperation. For the information of members who may be interested, some biographical notes are appended, concerning the training backgrounds of Doctor Kress and Mr. Hunton.

Respectfully submitted,

SPECIAL COMMITTEE ON CENTRAL OFFICE SURVEY.

Philip K. Gilman, *Chairman.*

Harry H. Wilson.

Henry S. Rogers.

♦ ♦ ♦

Biographical Data: George H. Kress, M. D., Secretary-Treasurer of California Medical Association, and Editor of "California and Western Medicine"

Birthplace: Cincinnati, Ohio.

Education: University of Cincinnati (B. S., 1896; M. D., 1899). Intern, Good Samaritan Hospital, Cincinnati, 1900. Assistant Surgeon, National Military Hospital, Dayton, Ohio, 1901-1902. California licentiate, 1903. Graduate work, University of Vienna, 1912 and 1921. Specialty: Eye, ear, nose, and throat.

† For complete roster of officers, see advertising pages 2, 4, and 6.

* For editorial comment, see page 205.

Los Angeles County Medical Association: Secretary, 1910-1918. Later, for some years, member of its Council. Ex-president. One of founders of its Certified Milk Commission, and for twenty-five years its secretary, also ex-chairman of same.

California Medical Association: Elected to Council in 1907, and reflected until 1927 when, as editor, became ex-officio councilor, to date. President, California Medical Association, 1917. Editor, *CALIFORNIA AND WESTERN MEDICINE*, March, 1927, to date. Secretary-Treasurer, July 1, 1938, to date.

American Medical Association: For some years a member of its House of Delegates. A vice-president in 1919-1920.

Miscellaneous Medical Affiliations:

Publications: For some years, editor: "Southern California Practitioner"; "Bulletin of California Association for Study and Prevention of Tuberculosis"; "Bulletin of Los Angeles County Medical Association." Author, "History of the Medical Profession of Southern California," 1911 (209 pages). Miscellaneous papers on medical topics.

California State Board of Public Health: For some years a member of the California State Board of Public Health (during administrations of Governors Rolph and Merriam; resigned on July 1, 1938.) For some years: chairman of Advisory Medical Board of Health Department of County of Los Angeles; member of Medical Board of Major Disaster Council of City of Los Angeles.

Tuberculosis: For some years: attending physician for nose and throat at Barlow Sanatorium; chief of staff, Los Angeles Helping Station for Tuberculosis. Ex-secretary and ex-president, Los Angeles and California Societies for Study and Prevention of Tuberculosis. Chairman of California State Survey Commission on Tuberculosis, 1913 (Commission brought into being State Bureau of Tuberculosis, and State subsidies to county sanatoria of proper standard). Recipient of gold and silver medals, two pamphlets in educational leaflet contest, International Congress of Tuberculosis, Washington, D. C., 1910.

Dispensaries and Hospitals: For some years: chief of staff of Selwyn Emmet Graves Memorial Dispensary of Los Angeles; member of senior staff and staff secretary, California Hospital of Los Angeles. At Los Angeles County Hospital, member of senior staff on eye service, 1912-1938, and chief of eye staff, same period. Also, member of Los Angeles County Hospital Medical Board, same period. Surgeon in charge, U. S. C. Student Army Training Corps, World War I. For some years: chairman of eye, ear, nose and throat committee, Department of Corrective Physical Education, Los Angeles City Schools. Recipient of silver medal, Ling Foundation, school health work.

Medical Schools: In College of Medicine of University of Southern California, professor of hygiene and secretary of faculty, 1906-1909. In Los Angeles Medical Department of University of California, secretary of faculty, 1909-1914; dean of the department, 1914-1938, resigning July 1, 1938, to become secretary-treasurer of California Medical Association. In College of Medical Evangelists, for some years, professor of ophthalmology, now emeritus professor in same.

Medical Societies: Member of Los Angeles County Medical Association; California Medical Association. Fellow, American Medical Association; Fellow, American College of Surgeons. Member, Los Angeles Clinical and Pathological Society (retired); American Board of Otolaryngology (cert.); member, Los Angeles Academy of Ophthalmology and Otolaryngology (ex-president); Pacific Coast Oto-Ophthalmological Society; American Academy of Ophthalmology and Otolaryngology; National Institute of Social Sciences. Ex-member of Board of Directors of Associated Hospital Service of Southern California.

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Biographical Data: John Hunton, Executive Secretary of the California Medical Association

Born: Omaha, Nebraska, 1903.

Education: Public schools of Omaha, Chicago and Evanston, Illinois, 1908-1918. Graduated from Phillips Exeter Academy, Exeter, New Hampshire, 1921. Entered University of Nebraska, School of Business Administration, 1922; left class in 1924.

Business Experience: Advertising salesman for Chicago Tribune and Architectural Forum, 1924-1928; assistant director of public relations, Chicago Trust Company (and through merger, the National Bank of the Republic, Chicago), 1928-1931; sales manager, Petaluma Laboratories, 1932; assistant editor and business manager of *The California Banker* (published by California Bankers' Association), 1933-1935; reporter (six months) and city editor (five years) of Pacific Coast Edition, *The Wall Street Journal*, San Francisco, 1935-1940.

ABSTRACT OF MINUTES: CALIFORNIA MEDICAL ASSOCIATION COUNCIL*

Minutes of the Two Hundred and Eighty-Ninth (289th) Meeting of the Council of the California Medical Association

Held in the Auditorium of the Los Angeles County Medical Association, 1925 Wilshire Boulevard, Los Angeles, Sunday, October 6, 1940, at 10:30 a. m.

1. Roll Call.

Present: Councilors Gilman (chairman), Wilson, Goin, Rogers, Cass, Emmons, McClendon, Maner, Packard, Kneeshaw, Cline, Hamlin, McDonald, Green, Anderson, Dewey, Moody, Best, and Kress. Absent: Councilors Dukes and Powell.

2. Minutes.

Minutes approved included: (a) Minutes of meeting of the Council held on June 29, 1940; (b) Minutes of meeting of the Executive Committee held on September 15, 1940; (c) Minutes of the meeting of the Committee on Public Relations held on September 15, 1940.

3. Membership.

(a) A report on the present membership of the Association was given by the Secretary, showing 6,508 active members, one honorary member, ninety-three retired members, and four associate members.

(b) Applications from component county societies for retired membership for Arnold Burkelman, Los Angeles; William Malone, San Francisco County; and Ferdinand Stabel, Shasta County, were presented and approved.

(c) All 1939 Association members whose dues had been received by the California Medical Association since the June 29, 1940, Council meeting were reinstated into membership. Carried.

(d) The Council approved the procedure requiring all applicants for membership to fill a State Association blank, same to be forwarded to the State Association office for the archives.

4. Placer County Medical Society.

Request of the Placer County Medical Society for a change of name to the Placer-Nevada-Sierra County Medical Society was granted. . . .

5. Annual Session.

The Council approved a plan to allocate a place on the opening morning program of the next annual session to discussion of problems of the State Board of Public Health.

6. Financial.

(a) Report of the Association Treasurer on September income and expense items and on balances in bank accounts as of October 3, 1940, were presented and accepted. It was stated that present indications were that income for this calendar year would exceed the budget estimate by about \$7,000, and that expenses on budgeted items might be \$7,000 less than the authorized allocations, making a possible total saving of about \$15,000 on the calendar year. Any deficit would be due to unforeseen and nonbudgeted items such as loans to California Physicians' Service. . . .

(c) Legal Counsel Peart was reauthorized to proceed with suit against the Government for refund of excise taxes and penalties paid by the Association for the years 1936, 1937, 1938, 1939, and 1940.

(d) The establishment of savings accounts for the Herzstein Bequest Fund of the California Medical Association in the Wells Fargo Bank and Union Trust Company and of the California Medical Association Permanent Endow-

* A mimeographed copy of the complete minutes has been sent to the secretaries of the county medical societies for the files of the component county units. Additional copies, for inspection by any member interested, are on file in the central office of the State Association, 450 Sutter, San Francisco.

ment Fund in the Bank of America, Humboldt branch, was approved.

(e) The Association Treasurer reported that the income for the calendar year 1940 would probably exceed the budget estimates by about \$7,000. Also that the expenditures for maintenance expenses as covered by budgeted items might be about \$7,000 or so less than the sums allocated or permitted in the budget. Therefore, the increased income and lesser expenditures might approximate a saving of something like \$14,000 for the calendar year. Any excess in expenditures for the year would be due to unforeseen, that is, to nonbudgeted items, such as loans to California Physicians' Service.

(f) It was moved, seconded and approved, that the "Trustees Of The California Medical Association" be requested to withdraw certain funds from their savings accounts, and to loan the same to the California Medical Association.

(g) It was moved by Lowell S. Goin, seconded by E. Earl Moody, and carried, that the pension granted Miss Lucile T. Bradford be set at \$40 a month for the fiscal year.

(h) A loan of \$5,000 to California Physicians' Service by the California Medical Association was reported.

7. Indemnity Defense Fund.

The Secretary reported on assignments of interest, and consents to distribute moneys of the Indemnity Defense Fund; the same being in response to a letter that had been mailed to 117 members of the Fund from whom assignments had not heretofore been obtained.

8. Basic Science Law.

The Committee on Public Relations reported on the fourth draft of the basic science initiative, and stated that the Legal Counsel was now making some minor changes in legal phraseology. Also, that it was hoped the two state dental associations and three dental schools would reach early decisions on the possibility of including the profession of dentistry in the Act.

It was hoped to have the revised fourth draft in early form to permit its submittal to the Attorney-General of California for a title. The authorization of the title is a necessary prerequisite to circularization of petitions for signatures of voters.

9. Committee on Public Health Education.

Dewey R. Powell, Stockton, submitted his resignation as a member of the Committee on Public Health Education. Accepted with regret.

10. Committee on Public Policy and Legislation.

Junius B. Harris of Sacramento submitted his resignation as a member, and as chairman of the Committee on Public Policy and Legislation.

It was moved, seconded and carried, that the Council accept with regret, and with thanks for past services, the resignation of Doctor Harris as a member of the Committee on Public Policy and Legislation.

Dr. Dwight H. Murray of Napa was appointed a member of the Committee on Public Policy and Legislation to fill the vacancy, and also as chairman of the Committee.

11. Delegates to the American Medical Association.

The Association Secretary informed the Council that because of the increased membership of the California Medical Association, it is now entitled to one more delegate to the American Medical Association.

Henry S. Rogers was elected as the additional American Medical Association delegate for the year 1941, and Philip K. Gilman was elected as his alternate.

12. Medical Preparedness.

(a) Philip K. Gilman, Chairman of the California Committee on Medical Preparedness, and Charles A. Dukes,

member of the California State Council of Defense, reported on medical preparedness plans.

13. Survey of Association Offices.

At this point the Council went into executive session, with John W. Cline as acting secretary. The minutes of the acting secretary for this session are as follows:

"Chairman Gilman reported concerning the method of selection of Mr. John Hunton as executive secretary of the California Medical Association. He stated that the salary offered by the Committee and accepted by Mr. Hunton would be \$350 per month for the months of October, November, and December, 1940. He further stated that the matter of Mr. Hunton's salary would be taken up at the January meeting of the Council and adjustment be discussed at that time. He asked that the Council ratify the action of the special Committee and the Executive Committee concerning the employment of Mr. Hunton.

"It was moved, seconded and carried, that Mr. John Hunton be employed as executive secretary of the California Medical Association at a salary of \$350 per month for the months of October, November, and December, 1940, and that his salary be reconsidered at the January meeting of the Council, with the intent to revise it upward if his services had proved satisfactory.

"A protracted discussion of the definition of the duties of the Secretary and the Executive Secretary took place.

"It was moved, seconded and carried, that the Special Committee, consisting of Gilman, Rogers, and Wilson, continue their study and submit a report of the entire reorganization plan in full detail at a special meeting of the Council to be held on October 20, 1940, in San Francisco.*

"It was moved, seconded and carried, that the Council approve the tentative outline of delineation of duties of the Secretary and Executive Secretary, and that the Chairman of the Council be instructed to inform the Secretary and Executive Secretary concerning their respective duties and powers at once.

"A plan for contract publication of CALIFORNIA AND WESTERN MEDICINE was discussed in some detail. The Special Committee of Gilman, Wilson, and Rogers was instructed to study this plan further and report to the special meeting of the Council, October 20, 1940.

"The resolution dealing with the creation of an editorial board was discussed. It was moved, seconded and carried, that the Chairman of the Council appoint a committee of three to consider this resolution and render a report to the Council at its special meeting of October 20, 1940."

14. Associated Hospital Service of Southern California.

Discussion was had of a new type of policy issued by the Associated Hospital Service of Southern California since August, 1939, covering x-ray diagnostic service, in addition to regular hospital services. The conflict of this type of policy with professional services offered under California Physicians' Service was discussed, and the question of the California Medical Association withdrawing its approval of Associated Hospital Service of Southern California was brought up.

It was moved by Lowell S. Goin, seconded by Harry H. Wilson, that the Council withdraw its approval of Associated Hospital Service of Southern California by December 1, 1940, unless changes in the hospital service contract were made to meet the requirements of the California Medical Association. Carried.

It was moved by Axel E. Anderson that a committee of three members be appointed by the Chairman, to be available to discuss with the hospital association the question of offering for sale professional services.

An amendment to this motion was offered by John W. Cline that two more members be appointed to this com-

* By mail vote, the Council decided not to hold the meeting on October 20.

mittee from the northern part of the State, and that this committee be instructed to make a survey and bring in a report on all nonprofit hospital associations in the State. The amendment was accepted by Doctor Anderson and the motion was seconded and carried.

The Council Chairman appointed as the committee: Donald Cass, Chairman; Edward B. Dewey, Pasadena; E. Earl Moody, Los Angeles; Elbridge J. Best, San Francisco; and Henry Rogers, Petaluma.

It was moved by Harry H. Wilson, seconded by Axel E. Anderson, and carried, that the decision of the Committee on nonprofit hospital association and of the Council in the case of the Associated Hospital Service of Southern California be conveyed diplomatically to the Insurance Association of Approved Hospitals (Alameda County).

15. Los Angeles County General Hospital.

E. Earl Moody told of the appearance before the Los Angeles County Board of Supervisors of a committee from the Los Angeles County Medical Association, at which time the supervisors were asked to place the medical activities of the Los Angeles General Hospital, Olive View Sanatorium, and the County Poor Farm, under the direction of a physician or a group of physicians.

The Council was asked to go on record in favor of medical control of medical activities of these institutions. Approval was given.

16. Department of Public Health.

A letter from the Los Angeles County Medical Association requested that the Council endorse a program of the State Department of Health for securing promises of retail druggists to free their shelves of all remedies advertised for the self-treatment of venereal diseases. Approval given.

17. Child Welfare Clinics.

Dr. John W. Green reported on the opening this fall of a Child Welfare Clinic in Vallejo, under control of local health officers and under the auspices of the Vallejo Women's Club. . . .

21. California Physicians' Service.

The Secretary reported that California Physicians' Service has advised that its beneficiary membership now totals 17,400 and that the agreed upon deduction from membership fees is now sufficient to pay the organization's maintenance expenses.

22. Indemnity Defense Fund.

Mr. Peart reported that all documents had been prepared and sent to the Trustees of the Indemnity Defense Fund and that copies of these documents would be forwarded to Lemuel P. Adams* on his return from Oregon.

23. Association of California and Western Hospitals.

An invitation from the Association of California Hospitals requesting the California Medical Association to send a representative to the Hospital Association's meeting at Fresno, November 9-10, 1940, was read and accepted. . . .

30. Date of Next Council Meeting.

The date of the next regular meeting of the Council was left in the hands of the Chairman, who announced tentatively that it would be called about the third or fourth week in February, when information on health measures presented at the opening session of the state legislature would be available.

32. Adjournment.

PHILIP K. GILMAN, *Chairman*.

GEORGE H. KRESS, *Secretary*.

ABSTRACT OF MINUTES: CALIFORNIA MEDICAL ASSOCIATION EXECUTIVE COMMITTEE

Minutes of the One Hundred Seventy-First Meeting of the Executive Committee of the California Medical Association, Held in San Francisco, Monday October 21, 1940

1. Roll Call.

Present: Doctors Dukes (chairman), Rogers, Gilman, Cline, Cass, and Kress. Absent: Doctors Wilson and Goin.

2. Minutes.

Minutes of the meeting held on September 15, 1940, were approved.

3. Financial.

(a) The financial report was submitted by the Association Treasurer, as per weekly report, dated October 21, 1940. Placed on file.

(b) The Treasurer reported that authority had been granted by the Trustees Of The California Medical Association to lend to the California Medical Association certain portions of the deposits mentioned in the weekly report dated October 21, and listed under Item 9: (a), (b), and (c). It was stated the total amount of the loan would be \$8,303.07.

(c) The Association Treasurer reported that the income for the calendar year 1940 would probably exceed the budget estimates by about \$7,000. Also that the expenditures for maintenance expenses as covered by budgeted items might be about \$7,000 or so less than the sums allocated or permitted in the budget. Therefore, the increased income and lesser expenditures might approximate a saving of something like \$14,000 for the calendar year. Any excess in expenditures for the year would be due to unforeseen, that is, to nonbudgeted items, such as loans to California Physicians' Service.

4. Membership.

(a) Membership status as of date of October 21 was reported. The total number of members as of good standing is 6,542, this figure being inclusive of 413 physicians who had become new members in the year 1940.

(b) The Executive Committee voted that component county medical societies should request applicants for membership to fill in the California Medical Association application form, even though a component county society used a blank of its own for its separate files. Also that the State Association form should be forwarded to the Central Office in San Francisco for placement in the Association files in order that adequate biographical and other data of every member may be on record.

5. Survey of Association Offices.

The special committee that was appointed by the Council, consisting of Council Chairman Gilman, President Wilson, and President-Elect Rogers, to which had been deputized the responsibility of making the necessary changes in the Central Office, in relation to the delineation of respective duties of the Secretary-Treasurer and Editor, and the Executive Secretary, reported through Council Chairman Gilman, and submitted a letter dated October 14, which had been sent to Secretary-Treasurer and Editor Kress and Executive Secretary John Hunton. Chairman Gilman reported that the arrangements had been harmoniously made, and to the satisfaction of all parties concerned.

It was voted that the action of the Special Committee be approved by the Executive Committee; and further, that the Council Chairman authorize a mail vote of the Council concerning the arrangements that had been made. Council Chairman Gilman also spoke of the proposed letter of information on the changes it was proposed should be sent to the component county societies; and also, of a

* Lemuel P. Adams died suddenly on October 27, 1940.

statement that would appear in the November issue of CALIFORNIA AND WESTERN MEDICINE.

6. Committee on Medical Preparedness.

(a) The Chairman of the California Committee on Medical Preparedness, Dr. Philip K. Gilman, spoke of the work now under way in the Central Office of the Association, whereby all California physicians who had not sent in their questionnaire blanks to the California Medical Association would be circularized.

(b) Dr. Charles A. Dukes, medical member of the California State Council on Defense, reported on the plans under way in relation to the Ninth Corps Area Induction Board, the twenty district boards, and the 283 local boards. The lists of physicians on these respective boards will be printed in the November issue of CALIFORNIA AND WESTERN MEDICINE (see page 224).

7. Basic Science Initiative.

Dr. Donald Cass reported that the Committee on Public Relations had practically completed its work on the proposed Basic Science Law, but the Executive Committee should act upon some of the provisions that were still under discussion. Report was made concerning the conferences with representatives of the dental profession and with other organizations. It was stated that the groups who had been interviewed were practically all in favor of the proposed law, even though a goodly number of modifications had been suggested.

The proposed changes to the fourth draft of the basic science law were discussed in considerable detail by Doctors Cass, Rogers, Cline, Gilman, Dukes, Wilbur, and Kress, and by Messrs. Peart, Hassard, and Read.

Upon motion by Doctor Cass, and seconded by Doctor Cline, it was voted that Dr. Dwight Wilbur, Chairman of the Subcommittee on Basic Science Law, be authorized to proceed with Mr. Hassard in making the final changes of the proposed law, with authority to consult Chairman Donald Cass and also others, if deemed desirable.

8. Associated Hospital Service of Southern California.

Minute No. 15 of the Council minutes of the meeting of October 6, 1940, was read by Chairman Philip K. Gilman. A general discussion followed on whether it was desirable to have a mandatory date of December 1, 1940, stipulated as the date of expiration of time at which certain changes must be made in policies issued to beneficiary members by the Associated Hospital Service of Southern California and of other nonprofit hospital organizations. The matter was considered not only from the standpoint of the principles involved, in so far as the same related to maintaining the integrity of medical services, and as being separate and distinct from hospitalization services and contracts. Considerable comment was also made concerning the possible effect of the proposed action upon the interests and development of California Physicians' Service.

Dr. Donald Cass, Chairman of the Special Committee of Five (Donald Cass, Edward B. Dewey, E. Earl Moody, Elbridge J. Best, and Henry S. Rogers), which had been appointed by the Council, stated he had communicated with the members of his committee and that they were in accord with the fundamental principles concerning medical service as outlined by the Houses of Delegates of the American Medical Association and the California Medical Association, but that the Committee was in doubt whether it had power to act further than to make a report. Doctor Cass stated he felt that the date limit of December 1, 1940, would not give sufficient time to carry on the negotiations that might be necessary.

Upon motion made by Doctor Cass, and seconded by Doctor Cline, it was voted that the Executive Committee approve an extension of time, and that the Chairman of the Council be requested to authorize a mail vote of the Council on the proposition that the Committee be granted an adequate extension of time beyond December 1, 1940, in which to conduct its negotiations, the Committee then to report to the Council. . . .

10. Legal Department.

A letter from a citizen of Visalia, in Tulare County, was read. Legal Counsel Peart reported thereon. It was suggested that a copy of the letter might be sent to the secretary of the Tulare County Medical Society and also to the physicians whose names had been mentioned in the communication. It was felt that the matter involved concerned local rather than state jurisdiction.

11. Socialized Medicine.

A letter from Dr. Don Weaver of Oakland, on the importance of educating members of the nursing profession concerning the significance of socialized medicine, was read.

The subject was referred to the Committee on Public Health Education for further study and possible action.

12. Malpractice Defense.

(a) A communication from D. T. Lundquist concerning the importance of working out methods of procedures concerning certain types of "expert witness testimony" was read. The Association Secretary was instructed to write Doctor Lundquist, informing him of the conferences that were being held on this subject between representatives of the Bar Association and Dr. Donald Cass, Chairman of the Committee on Public Relations.

(b) The Association Secretary called attention to the letter received from H. T. Woodward of Point Loma, in re the *Scott vs. McPheeters* case of Stockton, Doctor McPheeters having received in the said case the coöperation of the Medical Society of the State of California.

It was stated that the Medical Society of the State of California (Optional Medical Defense organization) had under consideration the correspondence between Dr. H. T. Woodward and the Legislative Counsel of the State of California in which certain amendments to the Civil Code in re rights of an unborn child were being proposed. In due course, these would be submitted to the California Medical Association Committee on Public Policy and Legislation. . . .

14. "Grievance Committee."

A letter having date of October 16, received from Dr. D. H. McNamara, Secretary-Treasurer of the Santa Barbara County Medical Society, was read. This letter had been previously referred to the legal counsel, Hartley F. Peart, who stated he would send to the Santa Barbara County Medical Society, the necessary information.

15. Report of Chairman Gilman.

For Council Chairman Philip K. Gilman, the Association Secretary reported on some telephone communications concerning contract and fee problems which had arisen in Monterey County. Council Chairman Gilman had decided that the matters at issue were in the nature of local problems and should be worked out by the component county society in Monterey, along such lines as in the judgment of the members of that unit were deemed best.

16. Adjournment.

CHARLES A. DUKES, *Chairman*.
GEORGE H. KRESS, *Secretary*.

"TRUSTEES OF THE CALIFORNIA MEDICAL ASSOCIATION"

Abstract of Minutes of a Special Meeting of the Board of Directors of the "Trustees Of The California Medical Association," Held in Los Angeles on October 6, 1940

1. Present: Philip K. Gilman (Chairman), Harry H. Wilson, Henry S. Rogers, Lowell S. Goin, John W. Cline, and George H. Kress.

2. Minutes of last previous meeting held on September 15, 1940, approved.

3. Report was made by the Secretary on the status of the various financial accounts and funds.

4. Report by the Secretary and Legal Counsel on membership and financial status of Indemnity Defense Fund. Authority was granted to the "Trustees Of The California Medical Association" to take over in due course the responsibilities of the present Trustees of the Indemnity Defense Fund (Doctors Lemuel P. Adams, Junius B. Harris, and Karl L. Schaupp).

5. Responding to opinion requested by the Secretary, Legal Counsel reported that all notes of California Physicians' Service for moneys loaned were in proper legal form, etc.

6. The officers of the "Trustees Of The California Medical Association" were granted authority to draw on three savings accounts held in the Bank of America, Crocker First National, and San Francisco Bank, but to leave at least \$100 in each of the three accounts. Permission was granted to loan such portion thereof as might be needed to the California Medical Association.

7. Authority was given the proper officers of the "Trustees Of The California Medical Association" to borrow up to \$10,000 additional from the Crocker First National Bank; and to loan the same to the California Medical Association should that Association find need and make request therefor.

8. Adjournment.

PHILIP K. GILMAN, *Chairman*.

GEORGE H. KRESS, *Secretary*.

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS

ROSTERS OF MEDICAL PERSONNEL ON VARIOUS SELECTIVE SERVICE BOARDS FOR CALIFORNIA*

In previous issues of the OFFICIAL JOURNAL, progress reports of the status of medical preparedness have been given, both in relation to the American Medical Association Committee on Medical Preparedness (Philip K. Gilman, M. D., San Francisco, Chairman for California) and for the California State Council of Defense (Charles A. Dukes, M. D., Oakland, member of Governor Culbert Olson's State Committee of Fifty).

It is now possible to present the complete lists as of date of October 20, for:

1. Appeal Boards;
2. Advisory Medical Boards of the twenty California districts; and
3. Doctors serving as medical examiners on the 283 local or community boards of California.

Rosters follow:

Doctors Engaged on Appeal Boards

Area 1—Eureka:
Walter W. Dolfini.....Eureka

Area 2—Redding:
Frank L. Doane.....Red Bluff

Area 3—Sacramento:
E. T. Rullison.....Sacramento

Area 4—Napa:
Robert S. Northrop.....Napa

Area 5—Stockton:
Jesse W. Barnes.....Stockton

Area 6—Oakland:
Arthur M. Smith.....Piedmont

Area 7—San Francisco:
Elwood R. Olsen.....San Francisco

Area 8—San Francisco:
Garnett Cheney.....San Francisco

Area 9—San Jose:
Joseph C. Cuneo.....San Jose

Area 10—Salinas:
W. H. Bingaman.....Salinas

Area 11—Fresno:
Clinton D. Collins.....Fresno

Area 12—Santa Monica:
Raymond Sands.....Santa Monica

Area 13—Burbank:
Robert A. Cunningham.....Pasadena

Area 14—Pasadena:
W. A. Swim.....Los Angeles

Area 15—Long Beach:
Francis Boas Settle.....Long Beach

Area 16—Los Angeles:
Alex A. Blatherwick.....Los Angeles

Area 17—Los Angeles:
Harlan Shoemaker.....Los Angeles

Area 18—Riverside:
Wayne K. Templeton.....Riverside

Area 19—San Diego:
Elmo G. Crabtree.....San Diego

Area 20—Santa Barbara:
Charles S. Stevens.....Santa Barbara

* * *

II

Doctors Engaged on Medical Advisory Boards

Area 1—Eureka:
Benjamin M. Marshall.....Eureka
Carl T. Wallace.....Eureka
W. J. Hoiilen.....Eureka
Raymond Babcock.....Willits
Max J. Goodman.....Eureka
Joseph M. Brown.....Eureka
Joseph S. Woolford.....Eureka
Vernon L. Hunt.....Eureka

Area 2—Redding:
Charles Pius.....Yreka
Chester D. Sewall.....Redding
James McGuire.....Mt. Shasta
Roderick Thompson.....Red Bluff
R. W. Jones.....Yreka
Frederick H. Olberg.....Redding
Earnest Dozier.....Redding
F. B. Godbolt.....Red Bluff
V. W. Hart.....Yreka

Area 3—Sacramento:
Junius B. Harris.....Sacramento
F. N. Scatena.....Sacramento
Maurice W. Haworth.....Sacramento
Raymond M. Wallerius.....Sacramento
Burt F. Howard.....Sacramento
Nathan G. Hale.....Sacramento
Orrin S. Cook.....Sacramento
Charles F. Gray.....Sacramento

Area 4—Napa:
Harry V. Baker.....Napa
Dwight H. Murray.....Napa
Gilbert L. Patterson.....Santa Rosa
Fred D. Heegler.....Napa
Robert B. Dempsey.....Vallejo
Mark L. Lewis.....Petaluma
Catherine M. Quinlan.....Santa Rosa
Harold A. Jack.....Napa
H. Randall Madeley.....Vallejo

Area 5—Stockton:
Earl R. McPheeters.....Modesto
George K. Wever.....Stockton

* For editorial comment, see page 204.

J. A. Porter.....	Modesto
George H. Sanderson.....	Stockton
Fred J. Conzelmann.....	Stockton
Hudson Smythe.....	Stockton
Charles D. Holliger.....	Stockton
C. B. Stabler.....	Stockton

Area 6—Oakland:

H. W. Harding.....	Oakland
A. A. Alexander.....	Oakland
A. Galbraith.....	Oakland
Harold Hitchcock.....	Oakland
Sydney K. Smith.....	Oakland
John A. Dougherty.....	Oakland
Alfred C. Siefert.....	Oakland
Harold G. Trimble.....	Oakland
Henry C. Petray.....	Oakland

Area 7—San Francisco:

Stanley Mentzer.....	San Francisco
Edwin L. Bruck.....	San Francisco
Robert C. Martin.....	San Francisco
Delbert Hand.....	San Francisco
V. H. Podstata.....	San Francisco
Sidney Olsen.....	San Francisco
Charles C. Fulmer.....	San Francisco
T. H. Pohlmann.....	San Francisco
Dohrmann K. Pischel.....	San Francisco

Area 8—San Francisco:

William Washburn.....	San Francisco
J. Marion Read.....	San Francisco
Edward C. Fabre-Rajotte.....	San Francisco
Merrill C. Mensor.....	San Francisco
Mervyn H. Hirschfeld.....	San Francisco
Tom E. Gibson.....	San Francisco
Irving S. Ingber.....	San Francisco
Chester W. Johnson.....	San Francisco
Percival Dolman.....	San Francisco

Area 9—San Jose:

R. S. Kneeshaw.....	San Jose
C. Kelly Canelo.....	San Jose
Paul T. Pace.....	San Jose
J. Bernard Josephson.....	San Jose
Pierce C. Barrette.....	San Jose
Dudley P. Fagerstrom.....	San Jose
Charles M. Richards.....	San Jose
J. Earl George.....	San Jose
P. T. Martin.....	San Jose
Joseph P. Schell.....	San Jose

Area 10—Salinas:

Fred R. Mugler.....	San Luis Obispo
Ira B. Bartle.....	San Luis Obispo
Wiley Reeves.....	Salinas
Rollin Reeves.....	Salinas
Mast Wolfson.....	Monterey
Albert J. Trinkle.....	Salinas
Harry Schultz.....	Salinas
D. M. Hitchcock.....	Salinas

Area 11—Fresno:

Robert W. Binkley.....	Selma
Roland B. Tupper.....	Fresno
G. W. Walker.....	Fresno
D. I. Aller.....	Fresno
S. S. Ginsburg.....	Visalia
Guy Manson.....	Fresno
W. H. McGehee.....	Fresno
Leland R. Packwood.....	Fresno
J. R. Walker.....	Fresno

Area 12—Santa Monica:

M. A. Desmond.....	Santa Monica
John P. Nuttall.....	Santa Monica
Richard Morrison.....	Santa Monica
Edward N. Reed.....	Santa Monica
Ross Moore.....	Santa Monica
Clayton Lane.....	Santa Monica
Albert T. Martin.....	Los Angeles
Cecil S. Dickinson.....	Santa Monica

Area 13—Burbank:

Erwin D. Pratt.....	Burbank
Karl P. Stadlinger.....	Burbank
A. Vincent Corty.....	Los Angeles
David Thomson.....	Burbank
Lawrence L. Craven.....	Glendale
J. C. Negley.....	Glendale
R. E. Brenneman.....	Glendale
C. E. Van Deventer.....	Burbank

Area 14—Pasadena:

Samuel J. Mattison.....	Pasadena
R. C. Olmsted.....	Pasadena
Leland G. Hunnicutt.....	Pasadena
William Arthur Clark.....	Pasadena
William Edler.....	Pasadena
Ben D. Massey.....	Pasadena
Francis B. Sheldon.....	Pasadena
Russell W. Porco.....	Pasadena
Russell M. Decker.....	Pasadena

Area 15—Long Beach:

R. A. Terry.....	Long Beach
Walter D. Gilkey.....	Long Beach
Dean E. Godwin.....	Long Beach
John I. Boyer.....	Long Beach
Richard A. Carter.....	Long Beach
George D. Stilson.....	Long Beach
W. E. Hart.....	Long Beach
Frank E. Weld.....	Long Beach
Russell T. Uhls.....	Long Beach

Area 16—Los Angeles:

E. C. Moore.....	Los Angeles
Arthur Stanley Granger.....	Los Angeles
Walter R. Crane.....	Los Angeles
Albert E. Gallant.....	Los Angeles
H. Douglas Eaton.....	Los Angeles
Elmer Belt.....	Los Angeles
Ray A. Carter.....	Los Angeles
Jas. S. Montague.....	Los Angeles

Area 17—Los Angeles:

Clarence G. Toland.....	Los Angeles
John V. Barrow.....	Los Angeles
Simon Jesberg.....	Los Angeles
Charles L. Hawk.....	Hollywood
Glenn Myers.....	Compton
George F. Schenck.....	Los Angeles
R. G. Taylor.....	Los Angeles
Homer A. Dahlman.....	Los Angeles
G. R. Owen.....	Los Angeles

Area 18—Riverside:

Ray B. McCarty.....	Riverside
Merrill W. Hollingsworth.....	Santa Ana
Erwin P. Miller.....	Riverside
F. E. Clough.....	San Bernardino
G. M. Webster.....	Patton
Ivan L. Finkelberg.....	San Bernardino
E. M. Johnston.....	Riverside
Colin C. Owen.....	San Bernardino

Area 19—San Diego:

Charles M. Fox.....	San Diego
James F. Churchill.....	San Diego
David R. Higbee.....	San Diego
Maynard C. Harding.....	San Diego
F. G. Lindemulder.....	San Diego
Edwin F. Chamberlain.....	San Diego
W. O. Weiskotten.....	San Diego
Leland D. Jones.....	San Diego
Terrell Scott.....	San Diego

Area 20—Santa Barbara:

R. W. Homer.....	Ventura
H. E. Henderson.....	Santa Barbara
William H. Johnston.....	Santa Barbara
W. Sterling Clark.....	Ventura
Thomas W. Hagerty.....	Camarillo
Milton John Geyman.....	Santa Barbara
Harry R. Hancock.....	Santa Barbara
Philip C. Means.....	Santa Barbara
Albert Q. Spaulding.....	Santa Barbara

* * *

III

Doctors Serving as Examining Physicians for Local Boards

Alpine Local Board No. 33:	
A. R. Thompson.....	Minden, Nevada
Amador Local Board No. 32:	
John Wakefield.....	Sutter Creek
Butte Local Board No. 15:	
Dan H. Moulton.....	Chico
Butte Local Board No. 16:	
Frank M. Whiting.....	Oroville
Calaveras Local Board No. 34:	
George P. Cooper.....	Angels Camp
Colusa Local Board No. 19:	
Charles F. Keith.....	Williams
Del Norte Local Board No. 1:	
Francis M. Stump.....	Crescent City

El Dorado Local Board No. 31:		
William A. Reckers.....	Placerville	
Glenn Local Board No. 14:		
Francis H. Gambell.....	Willows	
Humboldt Local Board No. 5:		
John N. Chain, Sr.....	Eureka	
Humboldt Local Board No. 6:		
Lowell G. Kramar.....	Fortuna	
Lassen Local Board No. 9:		
George S. Martin.....	Susanville	
Mendocino Local Board No. 12:		
Paul J. Bowman.....	Fort Bragg	
Lake Local Board No. 18:		
Charles A. Craig.....	Lakeport	
Modoc Local Board No. 4:		
Waldo H. Pate.....	Alturas	
Tehama Local Board No. 10:		
James L. Faulkner.....	Red Bluff	
Mendocino Local Board No. 13:		
Edward C. Bennett.....	Ukiah	
Nevada Local Board No. 22:		
Carl P. Jones.....	Grass Valley	
Placer Local Board No. 30:		
J. Gordon Mackay.....	Auburn	
Plumas Local Board No. 11:		
John W. Moore.....	Quincy	
Sacramento Local Board No. 24:		
Charles I. Titus.....	Sacramento	
Sacramento Local Board No. 25:		
James W. O'Brien.....	Sacramento	
Sacramento Local Board No. 26:		
Hermann E. Lorenz.....	Sacramento	
Sacramento Local Board No. 27:		
William H. Pope.....	Sacramento	
Sacramento Local Board No. 28:		
Paul W. Frame.....	Elk Grove	
Sacramento Local Board No. 29:		
Archibald A. Atkinson.....	North Sacramento	
San Joaquin Local Board No. 35:		
Arthur C. Boehmer.....	Lodi	
San Joaquin Local Board No. 36:		
Curtis M. Galt.....	Manteca	
San Joaquin Local Board No. 37:		
William P. J. Lynch.....	Stockton	
San Joaquin Local Board No. 38:		
Abram L. Van Meter.....	Stockton	
San Joaquin Local Board No. 39:		
Irving S. Zeimer.....	Stockton	
Shasta Local Board No. 8:		
Henry L. White.....	Redding	
Sierra Local Board No. 17:		
Vernon W. Padgett.....	Alleghany	
Siskiyou Local Board No. 2:		
Albert H. Newton.....	Yreka	
Siskiyou Local Board No. 3:		
Charles C. Dickinson.....	McCloud	
Stanislaus Local Board No. 40:		
Terry T. Laird.....	Oakdale	
Stanislaus Local Board No. 41:		
James L. Collins.....	Turlock	
Stanislaus Local Board No. 42:		
Ned B. Gould.....	Modesto	
Sutter Local Board No. 20:		
Neal M. Loomis.....	Yuba City	
Trinity Local Board No. 7:		
John D. Briggs.....	Weaverville	
Tuolumne Local Board No. 43:		
Homer D. Rose.....	Sonora	
Yolo Local Board No. 23:		
Fred R. Fairchild.....	Woodland	
Yuba Local Board No. 21:		
John A. Duncan.....	Marysville	
Alameda Local Board No. 56:		
Adams Paterson.....	San Leandro	
Alameda Local Board No. 57:		
George E. Koerber.....	Oakland	
Alameda Local Board No. 58:		
Parley P. Musser.....	Oakland	
Alameda Local Board No. 59:		
Edward H. Anthony.....	Oakland	
Alameda Local Board No. 60:		
A. Bradford Carson.....	Oakland	
Alameda Local Board No. 61:		
Clarence B. Foltz.....	Oakland	
Alameda Local Board No. 62:		
John Ohannesson.....	Alameda	
Alameda Local Board No. 63:		
Henry B. Mehrmann.....	Oakland	
Alameda Local Board No. 64:		
Charles L. Freytag.....	Oakland	
Alameda Local Board No. 65:		
William D. Desch.....	Piedmont	
Alameda Local Board No. 66:		
Rufus J. Newell.....	Oakland	
Alameda Local Board No. 67:		
George Douglas Ream.....	Albany	
Alameda Local Board No. 68:		
Clarence A. Wills.....	Oakland	
Alameda Local Board No. 69:		
Robert F. Legge.....	Oakland	
Alameda Local Board No. 70:		
Edward Gale Whiting.....	Berkeley	
Alameda Local Board No. 71:		
Fred E. Ewing.....	Oakland	
Alameda Local Board No. 72:		
Melvin G. Hart.....	Oakland	
Alameda Local Board No. 73:		
William Robert Reud.....	Oakland	
Alameda Local Board No. 74:		
Francis K. Kearney.....	Hayward	
Alameda Local Board No. 75:		
Eugene C. Grau.....	Niles	
Contra Costa Local Board No. 52:		
L. H. Fraser.....	Richmond	
Contra Costa Local Board No. 53:		
Kaho Daily.....	Richmond	
Contra Costa Local Board No. 54:		
W. S. Edmeades.....	Martinez	
Contra Costa Local Board No. 55:		
D. C. Wise.....	Pittsburg	
San Mateo Local Board No. 103:		
Edwin I. Bartlett.....	South San Francisco	
San Mateo Local Board No. 104:		
H. H. Whitney.....	Burlingame	
San Mateo Local Board No. 105:		
Norman D. Morrison.....	San Mateo	
San Mateo Local Board No. 106:		
Frank S. Gregory.....	Redwood City	
San Mateo Local Board No. 107:		
R. J. Gerlough.....	Menlo Park	
Santa Clara Local Board No. 108:		
C. S. Sullivan.....	San Jose	
Santa Clara Local Board No. 109:		
Donald R. Threlfall.....	San Jose	
Santa Clara Local Board No. 110:		
E. P. Cook.....	San Jose	
Santa Clara Local Board No. 111:		
Elliot Rouff.....	San Jose	
Santa Clara Local Board No. 112:		
Blake C. Wilbur.....	Palo Alto	
Santa Clara Local Board No. 113:		
William R. Harder.....	Los Gatos	
Marin Local Board No. 50:		
Carl F. Larson.....	Sausalito	
Marin Local Board No. 51:		
Harry O. Howitt.....	San Rafael	
Napa Local Board No. 47:		
George T. Pomeroy.....	Napa	
Santa Cruz Local Board No. 282:		
Stanley W. Dowling.....	Santa Cruz	
San Francisco Local Board No. 76:		
Val C. Holmer.....	San Francisco	
San Francisco Local Board No. 77:		
Alson R. Kilgore.....	San Francisco	
San Francisco Local Board No. 78:		
Reynold J. Ferrari.....	San Francisco	
San Francisco Local Board No. 79:		
George T. Lenahan.....	San Francisco	
San Francisco Local Board No. 80:		
Boris S. Herman.....	San Francisco	
San Francisco Local Board No. 81:		
Arthur H. White.....	San Francisco	
San Francisco Local Board No. 82:		
Henry L. Gardner.....	San Francisco	
San Francisco Local Board No. 83:		
Reginald F. Grant.....	San Francisco	
San Francisco Local Board No. 84:		
Joseph H. D. Roger.....	San Francisco	
San Francisco Local Board No. 85:		
Clarence B. Cowan.....	San Francisco	
San Francisco Local Board No. 86:		
Thomas J. Fitzpatrick.....	San Francisco	
San Francisco Local Board No. 87:		
Donald M. Campbell.....	San Francisco	
San Francisco Local Board No. 88:		
Gustav Robert Riga.....	San Francisco	
San Francisco Local Board No. 89:		
Adolph Gottschalk.....	San Francisco	
San Francisco Local Board No. 90:		
Herman Marcus.....	San Francisco	
San Francisco Local Board No. 91:		
Douglas G. Macpherson.....	San Francisco	
San Francisco Local Board No. 92:		
Bernard Strauss.....	San Francisco	

San Francisco Local Board No. 93:		Orange Local Board No. 173:	
Reuben H. Zumwalt.....	San Francisco	John A. Wood.....	Anaheim
San Francisco Local Board No. 94:		Orange Local Board No. 174:	
James Morrille George.....	San Francisco	Charles Glenn Curtis.....	Brea
San Francisco Local Board No. 95:		San Bernardino Local Board No. 148:	
John F. Drew.....	San Francisco	Charles N. Abbott.....	Ontario
San Francisco Local Board No. 96:		San Bernardino Local Board No. 149:	
Samuel J. Hurwitt.....	San Francisco	John B. Craig.....	Upland
San Francisco Local Board No. 97:		San Bernardino Local Board No. 150:	
Thomas W. Cornwall.....	San Francisco	J. J. H. Smith.....	Colton
San Francisco Local Board No. 98:		San Bernardino Local Board No. 151:	
Alfred Goldman.....	San Francisco	R. E. Dowd.....	San Bernardino
San Francisco Local Board No. 99:		San Bernardino Local Board No. 152:	
Charles E. French.....	San Francisco	E. L. Tisinger.....	San Bernardino
San Francisco Local Board No. 100:		San Bernardino Local Board No. 153:	
J. J. Kavanagh.....	San Francisco	A. D. Neubert.....	Redlands
San Francisco Local Board No. 101:		San Diego Local Board No. 160:	
Samuel A. Goldman.....	San Francisco	Edward A. Blondin.....	San Diego
San Francisco Local Board No. 102:		San Diego Local Board No. 161:	
Emile D. Torre.....	San Francisco	L. J. Langlois.....	San Diego
Solano Local Board No. 48:		San Diego Local Board No. 162:	
Ambrose J. Ryan.....	Vallejo	Alfred J. Cantoni.....	San Diego
Solano Local Board No. 49:		San Diego Local Board No. 163:	
Andrew P. Finan.....	Suisun	R. K. Tanaka.....	San Diego
Sonoma Local Board No. 44:		San Diego Local Board No. 164:	
Stuart Z. Peoples.....	Petaluma	Lloyd Myers.....	San Diego
Sonoma Local Board No. 45:		San Diego Local Board No. 165:	
William C. Shipley.....	Santa Rosa	Carl S. Owen.....	San Diego
Sonoma Local Board No. 46:		San Diego Local Board No. 166:	
Frank E. Sohler, Sr.....	Healdsburg	R. O. Logsdon.....	San Diego
Fresno Local Board No. 123:		San Diego Local Board No. 167:	
Allison A. Calaway.....	Fresno	G. B. Larabee.....	La Mesa
Fresno Local Board No. 124:		San Diego Local Board No. 168:	
Frank W. Pomeroy.....	Fresno	Charles R. Knox.....	El Cajon
Fresno Local Board No. 125:		San Diego Local Board No. 169:	
Henry Ehlers.....	Fowler	C. A. S. Kemper.....	Escondido
Fresno Local Board No. 126:		Santa Barbara Local Board No. 142:	
Chester M. Vanderburgh.....	Fresno	P. A. Gray, Jr.....	Santa Barbara
Fresno Local Board No. 127:		Santa Barbara Local Board No. 143:	
Lloyd B. James.....	Fresno	G. R. Luton.....	Santa Barbara
Fresno Local Board No. 128:		Santa Barbara Local Board No. 144:	
Bryson E. Cox.....	Coalinga	W. H. Conser.....	Santa Maria
Inyo Local Board No. 134:		Ventura Local Board No. 145:	
Harvey W. Crook.....	Bishop	Grundy C. Coffey.....	Ventura
Kern Local Board No. 137:		Ventura Local Board No. 146:	
Thomas T. Matlock.....	Wasco	Artemas J. Strong.....	Santa Paula
Kern Local Board No. 138:		Ventura Local Board No. 147:	
Harvey R. McAllister.....	Taft	John William Nielsen.....	Oxnard
Kern Local Board No. 139:		Los Angeles Local Board No. 175:	
Homer Rogers.....	Bakersfield	William R. Senseman.....	Lancaster
Kern Local Board No. 140:		Los Angeles Local Board No. 176:	
Moses Thorner.....	Bakersfield	W. H. Gundrum.....	Canoga Park
Kern Local Board No. 141:		Los Angeles Local Board No. 177:	
George S. Lambeth.....	Bakersfield	R. C. Rush.....	San Fernando
Kings Local Board No. 129:		Los Angeles Local Board No. 178:	
John A. Crawshaw.....	Hanford	Homer S. Wilson.....	North Hollywood
Madera Local Board No. 117:		Los Angeles Local Board No. 179:	
Smith A. Quimby.....	Madera	Carroll Simons.....	North Hollywood
San Benito Local Board No. 122:		Los Angeles Local Board No. 180:	
Joseph M. O'Donnell.....	Hollister	E. H. Thompson.....	Burbank
Mono Local Board No. 118:		Los Angeles Local Board No. 181:	
Clarence L. Scott.....	Bishop	Montague Cleeves.....	La Crescenta
Mariposa Local Board No. 114:		Los Angeles Local Board No. 182:	
John S. Webster.....	Mariposa	F. T. Read.....	Glendale
Merced Local Board No. 115:		Los Angeles Local Board No. 183:	
Ashley S. Parker.....	Merced	D. M. Ghrist.....	Glendale
Merced Local Board No. 116:		Los Angeles Local Board No. 184:	
LeRoy Hillyer.....	Los Banos	W. O. Leach.....	Glendale
Monterey Local Board No. 119:		Los Angeles Local Board No. 185:	
Martin McAulay.....	Monterey	Orrie E. Ghrist.....	Glendale
Monterey Local Board No. 120:		Los Angeles Local Board No. 186:	
Garth Parker.....	Salinas	Edward D. Ellis.....	Los Angeles
Monterey Local Board No. 121:		Los Angeles Local Board No. 187:	
Charles T. Bullard.....	King City	Karel B. Blahnik.....	Pasadena
San Luis Obispo Local Board No. 135:		Los Angeles Local Board No. 188:	
George K. Dunklee.....	San Luis Obispo	A. N. Bobbitt and Z. T. Malaby.....	Pasadena
San Luis Obispo Local Board No. 136:		Los Angeles Local Board No. 189:	
Alvin H. Wilmar.....	Paso Robles	Joseph T. Edward and K. W. Taber.....	Pasadena
Tulare Local Board No. 130:		Los Angeles Local Board No. 190:	
Ray Edward Cronemiller.....	Exeter	A. Vance Anderson.....	Pasadena
Tulare Local Board No. 131:		Los Angeles Local Board No. 191:	
Lewis L. Seligman.....	Dinuba	Scott D. Gleeten.....	Monrovia
Tulare Local Board No. 132:		Los Angeles Local Board No. 192:	
Elmo R. Zumwalt.....	Tulare	Forrest C. Swearingen.....	Pomona
Tulare Local Board No. 133:		Los Angeles Local Board No. 193:	
W. W. Tourtillott.....	Porterville	Robert Lee Smith.....	Pomona
Orange Local Board No. 170:		Los Angeles Local Board No. 194:	
Edward Lee Russell.....	Santa Ana	Hyman H. Greene.....	Baldwin Park
Orange Local Board No. 171:		Los Angeles Local Board No. 195:	
James Farrage.....	Santa Ana	Edward N. McKee.....	Los Angeles
Orange Local Board No. 172:		Los Angeles Local Board No. 196:	
John D. Ball.....	Santa Ana	Horace R. Beck.....	Los Angeles

Los Angeles Local Board No. 197:		Los Angeles Local Board No. 243:	
Herbert T. Cox.....	Los Angeles	George F. Harding.....	Santa Monica
Los Angeles Local Board No. 198:		Los Angeles Local Board No. 244:	
Marshall Lee Martin.....	Los Angeles	Oscar Anderson.....	Santa Monica
Los Angeles Local Board No. 199:		Los Angeles Local Board No. 245:	
Nathan Bronfeld.....	Los Angeles	Howard E. Horner.....	West Los Angeles
Los Angeles Local Board No. 200:		Los Angeles Local Board No. 246:	
Harry B. Breitman.....	Los Angeles	J. R. Perry.....	West Hollywood
Los Angeles Local Board No. 201:		Los Angeles Local Board No. 247:	
C. J. Hershey.....	Los Angeles	Harry H. Blodgett.....	Beverly Hills
Los Angeles Local Board No. 202:		Los Angeles Local Board No. 248:	
Dee M. Rees.....	Monterey Park	Frank M. Schmidt.....	West Los Angeles
Los Angeles Local Board No. 203:		Los Angeles Local Board No. 249:	
George W. Caldwell.....	Los Angeles	C. W. Craik.....	Venice
Los Angeles Local Board No. 204:		Los Angeles Local Board No. 250:	
Conrad I. Hubert.....	South Pasadena	Russell L. Sands.....	Santa Monica
Los Angeles Local Board No. 205:		Los Angeles Local Board No. 251:	
H. L. Gotfredson.....	South Pasadena	Powell W. Griffith.....	Los Angeles
Los Angeles Local Board No. 206:		Los Angeles Local Board No. 252:	
H. B. Rickabaugh.....	Alhambra	Louis D. Cheney.....	Los Angeles
Los Angeles Local Board No. 207:		Los Angeles Local Board No. 253:	
O. H. Hanson.....	San Marino	N. Curtis King.....	Los Angeles
Los Angeles Local Board No. 209:		Los Angeles Local Board No. 254:	
P. A. Foster.....	Los Angeles	John MacLean.....	Los Angeles
Los Angeles Local Board No. 210:		Los Angeles Local Board No. 255:	
Clarence S. Cook.....	Los Angeles	A. A. Sornsen.....	Los Angeles
Los Angeles Local Board No. 211:		Los Angeles Local Board No. 256:	
L. M. Kane.....	Los Angeles	Oluf S. Hansen.....	Los Angeles
Los Angeles Local Board No. 212:		Los Angeles Local Board No. 257:	
Vernon S. Downs.....	Los Angeles	Elmer A. Nelson.....	Los Angeles
Los Angeles Local Board No. 214:		Los Angeles Local Board No. 258:	
Albert T. Ingalls.....	Los Angeles	Howard R. Harner.....	Los Angeles
Los Angeles Local Board No. 215:		Los Angeles Local Board No. 259:	
William Ellery Bailey.....	Los Angeles	J. Clough Frudenberg.....	Inglewood
Los Angeles Local Board No. 216:		Los Angeles Local Board No. 260:	
George Herbert Miller.....	Los Angeles	L. C. Burwell.....	Los Angeles
Los Angeles Local Board No. 217:		Los Angeles Local Board No. 261:	
Charles S. Young.....	Los Angeles	Paul C. Lawyer.....	Inglewood
Los Angeles Local Board No. 218:		Los Angeles Local Board No. 262:	
Manuel Chavez.....	Los Angeles	Leo W. Fate.....	Hawthorne
Los Angeles Local Board No. 219:		Los Angeles Local Board No. 263:	
Verne R. Mason.....	Los Angeles	James H. Turner.....	Huntington Park
Los Angeles Local Board No. 220:		Los Angeles Local Board No. 264:	
Harry Fred Becker.....	Los Angeles	Arthur O. Turbow.....	Los Angeles
Los Angeles Local Board No. 221:		Los Angeles Local Board No. 265:	
Edward K. Prigge.....	Los Angeles	George M. Campbell.....	South Gate
Los Angeles Local Board No. 222:		Los Angeles Local Board No. 266:	
S. M. Alter.....	Los Angeles	Albert A. Ehrke.....	Compton
Los Angeles Local Board No. 223:		Los Angeles Local Board No. 267:	
Cesar George Cahen.....	Los Angeles	Clyde L. Smith.....	Maywood
Los Angeles Local Board No. 208:		Los Angeles Local Board No. 268:	
Albert F. Stelhorn.....	Rosemead	Earl Howard Welcome.....	Downey
Los Angeles Local Board No. 213:		Los Angeles Local Board No. 269:	
Robert E. Benveniste.....	Los Angeles	Ralph W. Maker.....	Norwalk
Los Angeles Local Board No. 224:		Los Angeles Local Board No. 270:	
E. L. Christensen.....	Los Angeles	Albert T. Charlton.....	Norwalk
Los Angeles Local Board No. 225:		Los Angeles Local Board No. 271:	
Lee Payne Rombeau.....	Los Angeles	Fred B. Clarke.....	Long Beach
Los Angeles Local Board No. 226:		Los Angeles Local Board No. 272:	
Charles C. Coghlan.....	Los Angeles	Ward Hannah.....	Long Beach
Los Angeles Local Board No. 227:		Los Angeles Local Board No. 273:	
Clarence H. Godard.....	Los Angeles	Walter H. Boyd.....	Long Beach
Los Angeles Local Board No. 228:		Los Angeles Local Board No. 274:	
A. H. Weitkamp.....	Los Angeles	Gaylord L. Fisher.....	Long Beach
Los Angeles Local Board No. 229:		Los Angeles Local Board No. 275:	
M. A. Welbourn.....	Los Angeles	R. B. Eusden.....	Long Beach
Los Angeles Local Board No. 230:		Los Angeles Local Board No. 276:	
William Sidney Bowers.....	Los Angeles	Walter B. Palmer.....	Long Beach
Los Angeles Local Board No. 231:		Los Angeles Local Board No. 277:	
Raymond Myer Kay.....	Los Angeles	Ernest I. Mulder.....	Compton
Los Angeles Local Board No. 232:		Los Angeles Local Board No. 278:	
W. M. Gearon.....	Los Angeles	A. J. Langan.....	San Pedro
Los Angeles Local Board No. 233:		Los Angeles Local Board No. 279:	
John R. Buckingham.....	Los Angeles	William M. Pearce.....	Wilmington
Los Angeles Local Board No. 234:		Los Angeles Local Board No. 280:	
Harry L. McCarthy.....	Los Angeles	Norman A. Leake.....	Torrance
Los Angeles Local Board 235:		Los Angeles Local Board No. 281:	
Charles A. Bailey.....	Los Angeles	Ernest G. Butt.....	Redondo Beach
Los Angeles Local Board No. 236:		Imperial Local Board No. 158:	
Elmer W. Little.....	Los Angeles	John L. Parker.....	Brawley
Los Angeles Local Board No. 237:		Imperial Local Board No. 159:	
Hugo M. Kersten.....	Los Angeles	Floyd A. Burger.....	El Centro
Los Angeles Local Board No. 238:		Riverside Local Board No. 154:	
Edgar H. Brown.....	Los Angeles	C. W. Girdlestone.....	Riverside
Los Angeles Local Board No. 239:		Riverside Local Board No. 155:	
Warren F. Clark.....	Hollywood	Newman K. Bear.....	Riverside
Los Angeles Local Board No. 240:		Riverside Local Board No. 156:	
Hugh J. Strathearn.....	Hollywood	Allan Bramkamp.....	Banning
Los Angeles Local Board No. 241:		Riverside Local Board No. 157:	
Edward F. Nippert.....	Hollywood	B. Gene Morris.....	Thermal
Los Angeles Local Board No. 242:		Santa Cruz Local Board No. 283:	
Silas Arthur Lewis.....	Hollywood	Henry G. Watters.....	Watsonville

Bulletin of Information *

(COPY)

STATE HEADQUARTERS SELECTIVE SERVICE
STATE OF CALIFORNIA
PLAZA BUILDING, SACRAMENTO

October 15, 1940.

To All Doctors Engaged in the Administration of the Selective Service of California.

Foreword.—The Medical Division of the Selective Service will disseminate direct information to you from State Headquarters, from District Coordinator's offices (Sacramento, San Francisco, Fresno, and Los Angeles), by medical inspectors in the field, through meetings in your districts and, when necessary, through the press and radio. We anticipate, particularly at the onset, some queries. Please feel free to contact us either through your District Coordinator's office or, if necessity arises, here—when any unanswered medical problem presents.

This communication is being issued with the idea of anticipating certain likely questions. We know that many of you have studied the Selective Service machinery. Notwithstanding this, we feel that a review of the organization and administration will be valuable. Of course, we shall limit our discussion to the medical aspect alone.

1. State Headquarters.

Here, the State Director of Selective Service has a "Medical Assistant." He is known as the "Chief, Medical Division, Selective Service, California."

The Chief of the Medical Division will—

(a) Establish close relations with all examining physicians.

(b) When necessary, will recommend meetings of examining physicians for the purpose of discussing the medical problems of Selective Service with the view of clearing up doubtful points.

(c) Visit local and Medical Advisory Boards for the purpose of observing, advising, and assisting such Boards in connection with physical examinations and medical decisions.

(d) Coordinate the work of inspection and examination with the view of gaining a steady even flow of conscripts, without delay.

(e) Study the causes of discharges at mobilization camps, with a view to the determination of the cause thereof. In so doing, corrections may be made at the source and efficiency maintained.

2. District Headquarters.

For administrative purposes and with the idea of some necessary decentralization in a large state such as California, District Headquarters have been established in Sacramento, San Francisco, Fresno, and Los Angeles. They have, at their head, a district coordinator. In these districts there shall be a *medical inspector*. Although these medical inspectors will be a part of the district organi-

zation, they will be working directly from the Chief of the Medical Division's office.

Their duties correspond to those of the Chief, Medical Division.

3. The Local Board and the Examining Physician for Local Board.

On a direct line from State Headquarters (with only the administrative unit of the coordinators between) comes this important board. It makes decisions! Attached to each local board (the Board area covers a population of about 30,000) is an *examining physician for the Board*. No examining physician shall examine for a Board any registrant who is his first cousin, or a closer relative, either by blood or marriage, or who is an employee or employer, or stands in the relation of superior or subordinate in connection with any employment, or is a partner or close business associate of the physician. The Board shall request the Governor to recommend the appointment of another physician for such registrant, or shall use the physician of another board.

Although it is quite apparent that the medical discussions of the local board will depend almost entirely on the opinion of its examining physician, it must be clearly understood that the examining physician's recommendations are advisory only, and it is the Board which decides. The examining physician has no vote in the deliberations of the Board.

We heartily recommend the free use of specialists on medical advisory boards when any doubt arises. Your local Board will have a list of the Medical Advisory Board to which you will refer registrants.

When any appeal is made from a classification determined by a local board—based on a report of physical examination—it must be made within five days after the mailing of the notice (Form 57) by entering the claim of appeal in the place required for that purpose on both copies of the report of physical examination (D. S. S. Form 200).

Also, when an appeal is made from a classification determined by a local board—based on a report of physical examination—if the local board has not obtained a report from the Medical Advisory Board, it should refer it to them for further examinations, report, and opinion.

When the local board receives the Medical Advisory Report (or, if report was received prior to appeal), then the local board transmits to the Board of Appeal the original Form 200, together with any additional evidence as to physical qualification.

If, in the case of an appeal, the Local Board, after receiving the report of the Medical Advisory Board, determines that the registrant shall be reclassified, it shall reclassify him in accordance with the rules governing reclassification, and shall not forward the appeal to the Appeal Board.

If the finding of the local board is not in accordance with the recommendations of the Medical Advisory Board, and an appeal is made from the decision of the local board as to physical qualifications of the registrant, the local board shall make a special report to the Board of Appeal of its reason for rejecting the recommendation of the Medical Advisory Board.

Merely because the registrant claims a physical disqualification in the questionnaire, it is not construed as a claim to the Board of Appeal from the refusal of the local board to classify the registrant in Class IV (f). A regular form of appeal must be pursued.

Registrants confined to homes or hospitals, or those presenting themselves with a temporary defect, will be given a reasonable delay, but they must be investigated by the examining physician of a local board. Any registrant who is quarantined because of a communicable disease shall be excused from examination until he is released from quarantine by the health authorities. Any registrant who is sick or who has some temporary defect, or is awaiting an operation, or who has any other good excuse, may be granted a reasonable delay for completing his physical examination.

If the case of a registrant, referred to the Medical Advisory Board, is not completed, because of a temporary defect, the local board will send the registrant back at the end of the period "fixed as temporary," or earlier if the local board believe the temporary defect has been removed, or unless it believes further delay necessary, or that further examination by the Medical Advisory Board is unnecessary, in which case it may proceed without further reference.

The office of the examining physician need not be in the office of the local board. The likelihood is that the majority of these examinations will be made in the offices of the examining physicians at a time suitable to them and the local boards.

As soon as a registrant is classified—on return of his questionnaire—in Class I, notice will be made to him to

* The "Bulletin of Information" for all physicians who are or will be engaged in the administration of the "Selective Service of California" is the official announcement sent out by Richard E. Mittelstaedt, Adjutant General of California, through Colonel Bert S. Thomas, Chief of the Medical Division.

For convenience in reference, the editor of CALIFORNIA AND WESTERN MEDICINE has given sequence numerals to the various subheads, and also prints herewith an index of the subheadings:

- Foreword
- 1. State Headquarters
- 2. District Headquarters
- 3. The Local Board and the Examining Physician for local Board
- 4. Why Referred to Medical Advisory Board
- 5. Medical Advisory Boards
- 6. Medical Members of Appeal Boards
- 7. Appeals with Respect to Registrant's Physical or Mental Qualification
- 8. Decisions as to Medical Qualifications of Registrants
- 9. Decision to Place Registrant in Class 4 (f) Without Physician's Opinion
- 10. Doubtful Cases (Physical)
- 11. Transfer of Physical Examination
- 12. Limited Service Group
- 13. Disposition of Registrants Discharged from Military Service at a Mobilization Camp
- 14. Examination of Registrants in Deferred Classifications
- 15. Self-Inflicted Physical Disqualifications—Feigning—Malingerers
- 16. Forms
- 17. Examination of Records
- 18. Expenses
- 19. The Medical Gauntlet
- 20. When Doctors in the Selective Service Will Start to Function
- 21. Promptness

appear for physical examination, regardless of any appeal. Appeal or no appeal, all progress of the registrant from the local board will be constant just as though no appeal had been taken. However, a registrant shall not be ordered to report for induction during the period in which there is pending any appeal duly made by him or in his behalf from an appealable determination of the local board, or during the period afforded him by the rules and regulations within which to make an appeal.

4. Why Referred to Medical Advisory Board.

Registrants will be referred to Medical Advisory Boards:

1. When there is a properly presented appeal of the registrant on the basis of a physical disqualification.
2. When in doubt about the registrant's physical qualification, the examining physician shall request the local board to send the registrant to a Medical Advisory Board.
3. Whenever the examining physician so requests.
4. Where a majority on a local board disagree on the advisory decision of the examining physician, and is dissatisfied with the examining physician's finding.
5. Where the appeal agent believes the Medical Advisory Board should render an opinion, and requests that registrant be sent to the Advisory Board.
6. When any qualified inspector so recommends, it should be most likely that his recommendation will carry the problem to the Advisory group.

5. Medical Advisory Boards.

Medical Advisory Boards will number twenty (20) in the state. Their centers are at Eureka, Redding, Sacramento, Napa, Stockton, Oakland, two (2) in San Francisco, San Jose, Salinas, Fresno, Santa Monica, Burbank, Pasadena, Long Beach, two (2) in Los Angeles proper, Riverside, San Diego, and Santa Barbara. As previously stated, each local board will be supplied with the list of the specialists of these Advisory Boards to which problems of desired advice may be referred. Volume One of Selective Service Regulations states that the Board shall consist of internists, eye, ear, nose and throat specialists, orthopedists, surgeons, psychiatrists, clinical pathologists, radiographers, and dentists—as a minimum.

In this state we have planned an urologist as an additional member.

It is the intent to refer registrants directly to the particular specialist involved, rather than to the Board as a whole. Those of you who are acquainted with the endorsement method of Army communication will, after studying D. S. S. Form 200 (Report of Physical Examination), find that the reference of a registrant to a Medical Advisory Board follows closely the same method.

There is a full form provided for a physical examination by a Medical Advisory Board. However, the specialist on a Medical Advisory Board is not required to make a complete examination of a registrant, but only to examine the registrant and render an opinion on that part of the examination for which the registrant is sent to him.

The Medical Advisory Board exercises no original nor appellate jurisdiction.

If the Medical Advisory Board delays its examination of a registrant more than three (3) days to await correction of a temporary defect, it shall return the registrant's Form 200 to the local board, with a statement (attached to Form 200, but not written upon it) of the cause of delay and the time when the registrant should return for further examination. The local board normally shall send the registrant and his Form 200 back to the Medical Advisory Board at the time specified. However, if the local board believes the defect corrected, it may send him back earlier; or, if it believes more delay is needed, it may set a later date; or, if it decides that further examination is unnecessary, it may proceed without sending him back to the Medical Advisory Board.

All entries made by the Medical Advisory Board on the original Form 200 will be copied by the local board onto the duplicate Form 200 in the registrant's file.

6. Medical Members of Appeal Boards.

The medical members of Appeal Boards (twenty boards in California conforming identically in location with the Medical Advisory Boards) naturally will be primarily concerned with making medical decisions. However, they are voting members of their Board on *all* questions put before the Board. These boards shall have jurisdiction to review any decision concerning the classification of a registrant by any local board in the area of the Board of Appeal, and to affirm, modify or reverse the decision, provided that an appeal has been filed with the local board. It shall have the same appellate jurisdiction to review any decision or classification submitted to it by another Board of Appeal for review. The decision of the Board of Appeal shall be

final, unless modified or reversed by the President. No member shall act on the case of a registrant who is his first cousin, or closer relative, either by blood or marriage, or who is an employee or employer, or stands in relation of superior or subordinate in connection with any employment, or is a partner or close business associate of the member.

7. Appeals with Respect to Registrant's Physical or Mental Qualification.

If the person (the registrant, any person who claims to be a dependent of the registrant, a Government appeal agent, the director of Selective Service, or the state director of Selective Service) appealing wishes the Board of Appeal to review a determination of the local board with respect to the registrant's physical or mental qualifications, the person appealing shall fill out and sign the form for appeal which appears on the report of physical examination (Form 200). The person appealing shall attach to the report of physical examination a written statement specifying the class in which the person appealing believes the registrant should be placed, calling attention to where the person believes the local board erred and directing attention to any information in the registrant's file, but may not produce new evidence not contained in the registrant's file.

In the case of an appeal involving a determination of the registrant's physical or mental qualifications, the local board, before forwarding the appeal to the Board of Appeal, shall send the registrant and evidence on his physical and mental qualifications to the Medical Advisory Board unless that board has already made a finding thereon.

The local board shall transmit to the Board of Appeal the registrant's file, including therein the report of physical examination (Form 200) and all other reports or evidence on the registrant's physical or mental qualifications only if these matters are involved in the review on appeal.

If, before acting upon any appeal the Board of Appeal deems additional evidence necessary, it shall return all papers in the case to the proper local board with a request that such evidence be secured.

After the Board of Appeal has reached its conclusions it shall make the proper entries of its determination on either the questionnaire or the report of physical examination (Form 200), whichever is applicable.

A registrant shall not be ordered to report for induction during the period in which there is pending any appeal duly made by him or in his behalf from an appealable determination of the local board, or during the period afforded him by the rules and regulations within which to make an appeal.

Concerning the finality of the Board of Appeal decisions, it should be pointed out here that decisions pertaining to physical qualifications of registrants are absolutely final, inasmuch as an appeal to the President is permissible only on the grounds of dependency. This means just one thing—no question of physical disqualification goes above the Appeal Board.

8. Decisions as to Medical Qualifications of Registrants.

All decisions as to physical standards demanded are clearly outlined in Volume Six of the Selective Service Regulations. This regulation will be available to you through your local board or your district coordinator.

If these regulations are laid down so specifically, it should seem that all decisions should be uniform. Past experience has proved that this is not so. Unquestionably, with the same high quality of examination, we shall find that Board number "X" has 5 per cent of its passed registrants rejected by the Army Mobilization Center examiners, Board "Y" has less than 1 per cent rejected. There can be only one conclusion—there have been two "interpretations" of the regulations. This office and our Medical Inspection Division will make every effort to gain uniformity.

All doctors will be concerned with making three (3) decisions, and only three (3):

1. Is the registrant qualified for general military service? (Class I (a or d).)
2. Is the registrant qualified for limited military service? (Class I (b or e).)
3. Is the registrant disqualified for military service, by reason of . . . ? (Class 4 (f).)

9. Decision to Place Registrant in Class 4 (f) Without Physicians Opinion.

A registrant may be placed in Class 4 (f) without physical examination (by the local board) if he has any obvious physical, mental or nervous disability which permanently disqualifies him for any form of military service. If the registrant is so placed in Class 4 (f), the Board prepares a report on Form 200 and sends a duplicate thereof to the Governor.

10. Doubtful Cases (Physical).

When in doubt about the registrant's physical qualification, the examining physician shall request the local board to send the registrant to a Medical Advisory Board.

The full Medical Advisory Board, or one or more of its members, as may be necessary in the particular case, shall act on the case. The Board, or one or more members, shall examine the registrant, record the findings on the Form 200, and return the Form 200 to the local board.

Upon receiving the report of the Medical Advisory Board, the examining physician shall enter his findings on the appropriate part of Form 200.

The local board copies the report of the Medical Advisory Board on the retained duplicate Form 200 in the registrant's file, and classifies as 1 (a or d) (b or e) or 4 (f).

11. Transfer of Physical Examination.

The registrant shall be transferred for classification—when a physical examination is required—if the examining physician cannot act on the registrant's case because disqualified; or if the physician withdraws from consideration of the registrant's classification because of any conflicting interest, bias, or other reason.

On receipt of application for transfer of physical examination, the local board of origin, if it approves the application, issues an order (Form 203) (one copy to local board of transfer, one to registrant, one for file) for such transfer. When the local board of transfer receives the order, it causes the registrant to get a physical examination and then determines his qualification for service.

The local board of transfer forwards to the local board of origin two (2) copies of Form 200, including findings, and reports of the Medical Advisory Board (if any) and findings of the Board of Appeal (if any) and files a copy.

The classification of the local board of transfer (or by Board of Appeal having jurisdiction of local board of transfer) is binding on the local board of origin (or Board of Appeal of origin), but if still further facts present and if the local board from which the registrant was transferred receives new evidence that might affect his classification, the Board shall send the evidence and the registrant's file to the Board to which he was transferred.

12. Limited Service Group.

The examining physician of the local board is urged to consult with the Medical Advisory Board concerning the limited service group and to familiarize himself with the specific requirements concerning limited service.

Registrants who have been classified by local boards for general military service and who are found by examining physicians at mobilization camps or stations to be physically unfit may, if qualified for limited service, be acceptable for such service, provided men of that classification are needed in the camp or station at that particular time.

The final decision as to acceptance or rejection of inducted men, under the regulations, rests with the examining physicians at mobilization camps or other stations to which the registrants are sent upon induction into the Service.

Local boards may classify a registrant as physically qualified for limited military service without reference to Medical Advisory Boards.

13. Disposition of Registrants Discharged from Military Service at a Mobilization Camp.

Upon receiving notice from the induction station that a selected man has been found not acceptable because physically unqualified, the local board shall reclassify him into Class 1-B or Class 4-F. In determining whether the man should be placed in Class 1-B or Class 4-F, the Board shall consider the induction record (A. G. O. Form 221) and the opinion of its examining physician.

A registrant reclassified as above shall not be again placed in Class 1-A unless the condition causing his rejection at the induction station entirely and permanently disappears.

14. Examination of Registrants in Deferred Classifications.

Registrants in deferred classes will not be examined physically except under special instructions issued by the director of Selective Service, or when a call is made for the induction into service of registrants of these classes.

15. Self-Inflicted Physical Disqualifications—Feigning—Malingers.

If a registrant claims an ailment or defect which the local board cannot detect, or if the local board believes him to be feigning the ailment or defect, it shall attach a statement of the facts and its opinion to both copies of Form 200.

If the local board believes that a registrant's disqualifying physical defects are self-inflicted or purposely caused to avoid military service, the Board shall immediately pre-

pare in duplicate a full statement of the facts and the Board's recommendation. The original of this statement, with the original report of physical examination (Form 200) shall be sent to the Governor, and the duplicate filed with the duplicate Form 200 in the cover sheet. If the registrant is capable of any duty at all, and the local board recommends his induction, the Governor shall transmit the record to the director of Selective Service, or may direct that the registrant be reported to a United States District Attorney for prosecution.

There might well be cases of self-inflicted injuries which might not be possible to classify, even in Class I (b). At any rate, the classification will be made in the lowest numbered classification possible.

16. Forms.

There is really only one form with which our medical personnel will be concerned:

D. S. S. Form 200 (there are Forms 201, 203, and 1000 which have a medical bearing, but they will be omitted here). The local board shall deliver the prepared form (200) to the examining physician before the date on which the registrant is to report. The examining physician shall fill out the appropriate parts of the Report of Physical Examination (Form 200) in duplicate.

D. S. S. Form 200 is entitled "Report of Physical Examinations." A study of this in relation to Volume VI, Selective Service Regulations, "Physical Standards," is imperative and must be immediate on availability of this regulation. Only the original of Form 200 should be signed.

The duplicate Form 200 is always kept on file in the local board. The original is the one sent to required boards and to the mobilization center.

Those of you who have been acquainted with Army correspondence will recognize that it closely follows the "endorsement" method for its completion as it travels from board to board.

17. Examination of Records.

Authorized officers from this headquarters will present credentials showing them to have access to all records and forms.

18. Expenses.

(A) Estimate by local, Appeal, and Medical Advisory Boards:

(a) When the organization of a local board, Board of Appeal, or Medical Advisory Board is completed, the chairman shall cause to be prepared an estimate of expenses for the first month of operations. The estimate shall be entered on D. S. S. Form 254, in duplicate and shall be signed by a member of the Board. The original shall be forwarded to the Governor and a copy retained in the file of the Board.

(b) Not later than the fifth day of each month thereafter a similar estimate of expenses for the month shall be prepared and submitted.

(B) Supplies and services for examining physician, and services for Medical Advisory Board:

(a) The chairman of each local board is authorized to request the state procurement officer for selective service to furnish such supplies as may be required by the examining physician of such board (D. S. S. Form 259).

(b) The chairman of each local board, or the chairman of a Medical Advisory Board, may authorize such special examinations and laboratory tests as he deems necessary and shall cause to be forwarded to the state procurement officer for payment the bill for such examinations and tests after affixing his approval. Certification for such bill shall follow instructions of Selective Service Regulations, Volume Five.

(c) Subject to paragraph 552 (S. S. R., Volume V, Finance), the chairman of a Medical Advisory Board is authorized to appoint office assistants for his Board; provided, however, that such persons shall be employed on a per diem basis only.

19. The Medical Gauntlet.

There has been some concern shown by certain agencies regarding the possible missing of medical disqualifications in the examination of registrants. They point out that in 1917-1918 many such were missed, and thus threw a permanent burden on the Government. This office has no sense of uneasiness on this subject. When one considers that four medical hurdles must be surmounted before the registrant becomes one of the Conscript Army, it is fairly certain that the inducted personnel will be a "good risk" group. Let us review the procedure:

The registrant is examined by an examining physician of a local board; he, when questionable, goes before a carefully selected Advisory group; his physical qualification, when necessary, is decided by an Appeal group. He then has the barrier of an examination near and/or at an Army

mobilization camp. The examination near and/or at this center will not be a glancing one, but will be conducted by a board of doctors, numbering about ten or more plus that of the regular Army doctor at the camp.

We feel that the thoroughness of the examination from the time the registrant is ordered before the examining physician of the local board until he is part of the conscript Army will be complete.

20. When Doctors in the Selective Service Will Start to Function.

Ten (10) days following registration day (October 16), October 26, questionnaires will go to registrants from the local boards. Some of these will be returned immediately, and all will be returned within five (5) days. As soon as the very first group of questionnaires are returned, the local boards will send notices to those registrants not deferred to report for physical examination. This will insure a steady stream, rather than a sudden overload on the examining physician.

21. Promptness.

All of us in the Medical Division in Headquarters, from personal knowledge, are acquainted with the call upon the physician for the filling of forms. Within the last five (5) to ten (10) years, in particular, this has become an exceptional burden. We know your problem, so, in asking for prompt replies, we might expect some few stoppages. However, through the Medical Society, through the Committee of National Defense, through the Judiciary, and through many other sources, we believe that we have made a careful selection of doctors in this patriotic work, and so will expect that promptness will be observed. When we point out to you here that at the end of twenty-two (22) days after registration, a Class I (a) list of enough registrants, ready to go, will be expected at National Headquarters, it is needless to add any further statement regarding the necessity of action.

The final word now, "Thank you" for your spirit of true patriotism.

FOR THE GOVERNOR.

RICHARD E. MITTELSTAEDT,
State Director of Selective Service.

Prepared by

Lieutenant-Colonel Bert S. Thomas,
Chief, Medical Division.

* * *

Medical Coördination Setup Will Have Profession's Support

NATIONAL DEFENSE GROUP NAMED BY PRESIDENT AND
HEADED BY OFFICIAL OF THE AMERICAN MEDICAL
ASSOCIATION IS HAILED BY ASSOCIATION'S
JOURNAL

The coördinating committee for medical preparedness recently appointed by President Roosevelt will have the full confidence and coöperation of the medical profession, *The Journal of the American Medical Association* for September 28 declares in an editorial.*

"An executive order," *The Journal* says, "was issued on September 19, setting up, with the approval of the President, under the Council of National Defense, a subordinate body to the Council, to be known as the Medical and Health Committee. The chairman of this organization is Dr. Irvin Abell (Louisville, Kentucky), who is also chairman of the American Medical Association's Committee on Medical Preparedness. The order defining the establishment of the committee and its duties follows:

Pursuant to the authority vested in it by Section 2 of the Act of August 29, 1916 (39 Stat. 649), the Council of National Defense, with the approval of the President, hereby establishes as a subordinate body to the council a committee to be known as the Health and Medical Committee. The committee shall consist of the following members: Dr. Irvin Abell, who shall be chairman, the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, and the chairman of the Division of Medical Sciences of the National Research Council. Vacancies occurring in the membership of the committee shall be filled by appointment by the council with the approval of the President. The members of the committee and of such subcommittees as may be formed by the committee shall serve as such without compensation but

shall be entitled to actual and necessary transportation, subsistence and other expenses incidental to the performance of their duties.

It will be the responsibility of the committee to advise the Council of National Defense regarding the health and medical aspect of national defense and to coördinate health and medical activities affecting national defense. In carrying out its functions the committee may (a) utilize, to the extent that such facilities are available for such purpose, the laboratories, equipment and services of the Medical Departments of the Army and Navy, of the Public Health Service and of other government institutions, and (b) within the limits of the appropriations allocated to it, to contract with and transfer funds to such institutions and to enter into contracts and agreements with individuals or educational or scientific institutions for studies, experimental investigations and reports.

The committee shall promulgate rules and regulations for the conduct of its work, which rules and regulations shall be subject to the approval of the council and the President.

"This executive order brings to a favorable conclusion a cause for which officials of the Association, representing the Board of Trustees and the House of Delegates, have labored persistently since the annual session (of the Association) in June. The work of the American Medical Association, in the development of personnel for the military services, for industrial medicine and for maintaining the health of the people, can be carried forward with far greater efficiency through the establishment of some relationship directly with the Government. The work of the National Research Council in the investigation of procedures to be carried out for military purposes, in the development of information to be circulated to the medical profession and in the standardization of military medical procedures will also be greatly facilitated by this coördinating committee.

"No doubt announcements will issue in the near future from the coördinating committee, indicating the nature of its activities and the coöperation that will be required from the medical profession. Under the leadership and with the membership of the committee that has been established, the medical profession may give to this committee its complete confidence and an assurance of full coöperation."

* * *

American Medical Association Questionnaires: Their Importance

A. A. Alexander, President of the Alameda County Medical Society, in the bulletin of that component society, wrote as follows:

(Copy)

PRESIDENT'S MESSAGE

We are told that Washington is in a turmoil endeavoring to foresee and plan for all the contingencies involved in our preparedness campaign. It is no mean task to call up, equip, and train a half-million men and their officers. To keep those men in health will require many additions of the existing medical personnel. The last war mobilization saw a most frightful confusion. Profiting by the lessons of that period the Army and Navy are seeking the assistance of the medical profession through the American Medical Association and its component organizations. With that purpose in mind, questionnaires have been sent to all physicians in the country. The response has been somewhat dilatory. This step is in no sense a move toward a "draft" of Medicine. It is rather an effort in a forehanded way to take an inventory of available service. It contemplates an arrangement for recognition of specialized training, it hopes that only a minimum of personal disturbance may be necessary. In filling out and forwarding the questionnaire you do a favor to organized medicine, to your country, and, most of all, to yourself. For be sure the needs of the new defense forces will be served. Your

* For lists of subcommittees, see *Journal of the American Medical Association*, November 2, 1940, on page 1551.

coöperation may give you some voice as to when or where, and in what capacity you will be called to service.

Don't delay longer! The need is urgent!

Send in your questionnaire today.

Sincerely,

A. A. ALEXANDER, *President*.

* * *

Re: Selective Training and Service Act of 1940

(Copy)

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago.

The Presidents, Secretaries and Chairmen of the Legislative Committees of the State Medical Associations, Addressed.

An Act to prepare for the common defense by increasing the personnel of the armed forces of the United States and providing for its training, officially designated as the "Selective Training and Service Act of 1940," but more commonly referred to as the Conscription Act, was approved by the President September 16. I enclose a copy of the Act as approved. It will not contain the specific answers to all of the questions that will arise under it, but it may help you to answer some of them.

An abstract of the proceedings of the Conference on Medical Preparedness held at the headquarters of the Association, September 20, was published in *The Journal of the American Medical Association*. The applicability of the Conscription Act to medical students, to interns, to residents and to physicians generally were among the topics explored during the conference. . . .

Yours truly,

J. W. HOLLOWAY, JR.,
*Acting Director, Bureau of Legal
Medicine and Legislation.*

* * *

Exacting Teamwork Required in Selecting Emergency Army

The physical selection and care of the army, a task which always necessitates the most exacting and unremitting work on the part of highly trained men, in time of emergency requires even greater organization and teamwork, George A. Skinner, M.D., Berkeley, California, points out in the October issue of *Hygeia, the Health Magazine*.

"It is still necessary," he declares, "to have an army largely composed of carefully selected, physically fit youth, if it is to operate successfully under all conditions, particularly the unexpected ones that always develop in actual combat." The substitution of older men or of those who are partially incapacitated physically, he says, will not work because such men rapidly break down under stress, requiring at least one man and often two or three to care for each disabled individual. Men who have passed the entrance examination generally resist most of the usual causes of disability.

The examination usually begins by putting the candidates through various exercises to determine whether all joints are normal. "The general examination for hernia, hemorrhoids, condition of the feet, skin, and glands may then be made," Doctor Skinner says. "The eyes, ears, nose, throat, teeth, heart, lungs, and nervous system are examined individually by specialists in these fields.

"At each point the printed physical examination form which the man keeps with him during the examination is taken by an attendant and a record of observations is made. At any point in the examination, if a question arises,

the candidate is referred to a board of specialists for further examination. When all the findings are approximately normal, military clothing is provided for the individual. For this he is carefully measured, particularly his feet. He is required to stand on each foot while a load approximating his pack is placed on his back. The shoes he is given are larger than those he has been accustomed to wearing, but after he has marched during physical training exercises, he soon realizes the comfort of these more roomy shoes.

"New men are vaccinated as soon as possible against smallpox and typhoid fever. Tetanus (lockjaw) preventive may also be added.

"Military training starts at once and the men are gradually accustomed to physical exercise. Many minor defects exist among accepted men and these are listed for correction by the medical department as rapidly as possible. Personal cleanliness and the care of the feet and teeth must be a part of every soldier's training.

"The food supply of the army is most important. One of the duties of the medical department is to inspect food, not only before it is prepared but during its preparation and serving.

"With every group of men, contagious diseases soon appear. This is so predictable that it is often customary to isolate all new arrivals at training centers until a reasonable quarantine period has passed. With the first appearance of symptoms of a contagious disease, the suspect is at once removed to the hospital for further observation.

"It is not easy to keep an army physically fit, but it can be done to an extent that would have been unbelievable to army leaders two generations ago. Disease is now expected to cause less disability than injuries, but this has only been accomplished within the last half century. Previously battle injuries were far less than the disabilities caused by sickness."

* * *

Preparedness Program Geared for Military and Civilian Nursing

After twenty-two years of disaster fighting and caring for the emergency ills of a nation at peace, the American Red Cross Nursing Reserve again is being called for active duty with the United States military forces.

Moving swiftly to meet the nursing needs of a growing army and navy, this army of trained, uniformed women already is answering the call to national defense. Their ranks will grow with the progress of conscription, according to military plans. By next July, four thousand nurses will be called by the Army to augment the corps of one thousand Red Cross nurses who have been serving the peacetime forces.

Should the need arise, the Red Cross potentially can summon a nursing corps of 43,000—the full strength of its present nursing reserve. These women trained in hospitals throughout the country have met qualifications laid down by Red Cross nursing authorities. More important, they have pledged themselves for duty on a moment's notice in time of emergency, whether it be war, disaster or epidemic.

National defense measures being taken by the Red Cross Nursing Services are not confined to providing nurses for the army and navy, it was pointed out here by Miss Mary Beard, national director. Civilian nursing in time of national emergency is a vital factor being considered in the current defense program, she said.

Plans call for making available to the military forces, if necessary, 17,000 nurses, who comprise the first reserve. The remainder of the 43,000 Red Cross nurses would serve "behind the lines," ready to meet such emergencies as the epidemic influenza of the first World War and the threat of national disaster.

Despite the large number of nurses now enrolled in its reserves, the Red Cross has embarked on a program to strengthen the number to provide the best corps obtainable in the event of national emergency.

An equally vital part of the defense program of the Red Cross Nursing Service will be the recently announced plan to train "nurses' aides" in major metropolitan hospitals. The practicability of the project was determined when a selected group of Washington women were given a special course consisting of one hundred hours of lectures, classroom practice, and practical field work under the direction of the registered nurses.

* * *

Plans for Preventive Measures Against Syphilis and Gonorrhea: Protection of Armed Forces of the United States

A major educational offensive to defend America's armed and industrial forces against the threats of syphilis and gonorrhea was recently launched by the United States Public Health Service.

Surgeon-General Thomas Parran, in a letter to State Health Officers, announced plans to acquaint every man registering on October 16 under the Selective Service and Training Act with the facts about syphilis and gonorrhea and their relation to national defense, and urged that registrants have blood tests for syphilis.

"Registrants for America's first peacetime draft," Doctor Parran pointed out, "make up the age group in which is concentrated most cases of infectious syphilis. Blood tests of this group will lead to the discovery of a large number of cases of syphilis in the stage of the disease during which treatment is most effective. Stopping the spread of syphilis among this group would bring the control of syphilis among the whole population nearer by many years."

In the first World War venereal disease ranked as the third highest cause of disability. Almost 350,000 officers and men received treatment during the year and a half the United States was in the war. "Men infected with syphilis or gonorrhea and untreated cannot efficiently perform their duty of defending America," Doctor Parran said.

"Discovery and treatment of syphilis among registrants now will increase the reservoir of men available for active and efficient duty in the armed forces and in industry. An educational campaign coördinated with an extensive blood-testing program will not only discover many hidden cases, but with the facts about syphilis in the hands of all young men between twenty-one and thirty-six, we may expect a reduction in the number of new infections."

To open the nation-wide educational program, plans have been laid to provide each of the 16,500,000 registrants with a leaflet urging that he take a blood test as part of an initial check on his physical fitness. The Public Health Service has prepared "mats"—moulds from which type forms are cast—so that each State and large cities can print the folders economically and quickly.

Posters and other educational materials are being developed in coöperation with state and local health authorities for use on registration day and for concerted campaigns during the next few months.

The program will emphasize the importance of everyone having a blood test made by his physician, or in a public clinic if he is not financially able to pay for a test by a private physician. Infected persons will be urged to obtain expert medical care at once.

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NEWS ITEMS ON MEDICAL PREPAREDNESS

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More Guardsmen Face Mobilization

37,000 Additional Slated to Go Into Active Army Duty

Washington, September 19 (AP).—Tentative plans for calling 37,000 more national guardsmen to active duty in

November were announced today by Secretary of War Stimson, while airmail planes rushed master copies of civilian draft registration forms to central points in each state. . . .

Army officials computed that they would need 32,000,000 registration cards, 24,000,000 registration certificates and 24,000,000 questionnaires. No explanation was given as to the size of these figures when compared with the 16,500,000 who are to be registered.

Committee Named

At the White House, the day produced the appointment of a committee to coöperate with the National Defense Commission on all phases of public health.

President Roosevelt, acting under the authority of a 1916 law, named a group of five headed by Dr. Irvin Abell of Louisville, Kentucky, chairman of the board of regents of the American College of Surgeons. Other members are Dr. Lewis H. Weed, chairman of the division of medical sciences of the national research council; Rear Admiral Ross T. McIntire, surgeon general of the Navy and White House physician; Major General James C. Magee, Army surgeon general, and Dr. Thomas Parran, head of the public health service.

For Examinations

McIntire said problems for the committee would be mustering 16,000 physicians to examine men called under the draft act, and seeing that military needs for medical help were filled without upsetting the "civilian side" of medical care. . . .—*San Francisco Examiner*, September 20.

* * *

Medical Defense Should Keep Abreast of Times

United States Surgeon General Thomas Parran says in a report that this country is woefully unprepared in medical defense.

She has stores of opium and morphin, but she is lacking in many of the essentials which would be required to preserve the health of an army operating in South America. Quinin supplies from the East Indies are practically cut off. Nor are there large scale hoards of medicine with which to fight malaria. Likewise the country has an insufficient amount of vaccine to combat yellow fever.

These deficiencies are serious, yet Parran considers other conditions concerning medical defense equally insecure. For instance, he urges the appointment of a coördinator of medical and health preparedness and a survey of physicians and technicians since some 7,500 doctors alone are needed for each 1,000,000 men under arms.

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The World War, he says, resulted in some counties being stripped of their medical men while the staffs of some medical schools and hospitals were depleted of physicians.

Furthermore, intensive medical supervision he holds is necessary for the civilian population engaged in preparedness activities. Sickness at such a time is a drain upon the effectiveness of any national effort.

Undoubtedly he is not overstating the part which medical preparedness plays in any movement to stiffen the national backbone. Preparation on this front is exceedingly important because if it is neglected much of the effort to acquire impregnable defense becomes lost motion.—*Fresno Bee*, October 2.

* * *

Great Force of Physicians Is Prepared for Army Service*

Washington, October 2.—When "MM Day"—medical mobilization day—arrives more than 5,000 physicians will be in uniform.

Today at least 500 already have been called from the officers reserve corps and national guard ranks to go into active duty training and prepare for the physical examination of the first contingent of 400,000 men who will be called for a year of service. More than 200 reserve flight surgeons have been called by the air corps. In addition thousands will serve as examining officers on local draft boards to eliminate men with major physical defects.

The American Medical Association already has taken a census of its more than 100,000 member physicians, listing their ages, training, specialty, marital status, reserve commission if any, number of children and other pertinent data.

All of the facts are recorded on punched cards for immediate reference by army, navy or marine corps officers.

* By Stephen J. McDonough, Associated Press Science Writer.

Can Supply Wants

For instance, if the army should need an orthopedic surgeon for special duty at any camp or post in the country, the association, within a comparatively few minutes, can sort out the names of all the orthopedic surgeons in nearby states for possible enlistment.

The association said in an editorial in its journal that "the duty of the physician associated with the draft board is one of the utmost importance in relationship to securing a proper personnel for military service" in order to choose the most fit and detect malingerers trying to escape service.

The purpose of the present organization of medical examinations "is to eliminate to a certain extent the number of men who are ordered into service and subsequently have to be rejected, and to eliminate as far as possible the responsibility of the Government to individuals who will be without military value."

Physicians in Reserve

Virtually every physician graduated during the past twenty years has received a commission in the Officers Reserve Corps and most of these have been kept in force.

The army at present could call any Reserve Corps physician holding the rank of captain, colonel, or general, and after October 16 any physician may be called, whether he is a country practitioner or a noted specialist in brain surgery.

The ratio of medical men to other soldiers will be approximately one per company as the recruiting proceeds, counting diagnosticians, ophthalmologists, psychiatrists, x-ray specialists, and surgeons attached to various units or working in army hospitals. In addition, at least 70,000 nurses, inspectors, technicians and laboratory workers will be called into service.

Will Take Specialists

Officers of the army and navy medical corps say many of the top-ranking members of the profession will be recruited just as leading industrial experts are being taken from their jobs.

"However," they added, "all the cream will not be skimmed" from the medical profession now in private practice because it is equally as necessary to maintain the health of the civilian population as that of the armed forces.

The studies of medical students and internes will not be interrupted under the medical recruiting program, they added, since a continuous flow of trained medical men is needed and the men in training will be more valuable as officers than in duty in the ranks.—*Sacramento Bee*, October 2.

* * *

Draftee Physical Standards Set

Washington, October 23 (AP).—Physical standards for men to be drafted into the army, as published today, will include:

Height—Sixty inches minimum and 78 inches maximum.

Weight—One hundred five pounds minimum (those whose weight is so great as to interfere with training will not be accepted).

Eyesight—Normal vision or a minimum sharpness of 20-100 in each eye, which can be corrected with glasses to 20-40 (the 20 represents the distance of 20 feet which a patient stands away from a test chart, and the 40 represents the size of the type on the lowest line of the chart which he can read; since 20-20 is normal vision, 20-40 is roughly half of normal).

Hearing—Normal hearing (the ability to hear a low conversational voice at 20 feet with each ear separately) or minimum hearing in each ear of 10-20 (which means ability to hear at 10 feet the conversational voice which a normal ear can hear at 20 feet).

Diseases—Mild cases of many diseases will be overlooked, but those with such diseases as cancer, active tuberculosis, acute rheumatic fever, osteomyelitis, chronic arthritis, and late syphilis will be rejected. Every man examined for possible army service will be given a blood test for syphilis.

Teeth—A minimum of three chewing teeth above and three below, meeting each other, and three cutting teeth above and three below, also meeting. Teeth which have been or can be easily restored will count, as well as bridge-work.

Feet and Hands—Some defects are permissible, such as an absent left thumb, loss of two fingers of either hand, except where the two are the right index and middle finger, a slight club-foot, web fingers and toes unless severe, and absence of one or two small toes if the foot otherwise is good.

Minimum standards for men of various heights follow:

Inches	Weight	Chest Measure With Breath Exhaled
60	105	28¾
65	115	30
70	133	31¼
75	153	32½
78	165	33¼

Those are not standard weights and measures, but the minimum for acceptance. From 60 through 66 inches, two additional pounds of weight are required for each additional inch in height. From 67 inches up, four extra pounds are required for each inch.—*San Francisco Call-Bulletin*, October 23, 1940.

* * *

Conscription Dodge Tricks Are Exposed

Washington, October 23 (AP).—A book that is wise to all the tricks and artful dodges will aid selective service medical examiners in exposing fakers who attempt to evade the draft by pretending to be ill or disabled.

Going out from national draft headquarters to the forty-eight states today, the volume contains physical standards for men to be drafted into the army. The standards are slightly less exacting than regular army requirements.

List Regulations

Broadly, the regulations state that, to be eligible for the army, a registrant "must be able to see well; have comparatively good hearing; have a heart able to withstand the stress of physical exertion; be intelligent enough to understand and execute military maneuvers, obey commands and protect himself; and be able to transport himself by walking as the exigencies of military life may demand."

Doctors attached to each local draft board will examine all men who are placed in Class 1—available for service—on the basis of their answers to the draft questionnaire which will be sent to all 17,000,000 men who registered last week. Questionnaires will be mailed in the order in which the serial numbers of draft-age men are drawn in next Tuesday's national lottery here.

Classifications

In the order of the lottery, Class 1 men will be given physical examinations and further classified as follows:

Class 1A—Men qualified for general military service (certain college students will be placed in Class 1D until the end of the present school term; certain conscientious objectors will be listed among the unfit).

Class 1B—Qualified for limited military service.

Class 4F—Totally and permanently disqualified.

It is anticipated that only those in Class 1A, about one man in every five registered, will be called for training under the present program. Others might be called in an emergency.

Tests for Registrants

Local doctors are instructed by the regulations to watch for malingerers who feign disqualifying physical defects and for patriots who attempt to hide defects in order to get into the army.

Men suspected of malingering may be reported to the national director, or to the local United States Attorney for prosecution. Those who maim themselves may be forced to serve anyway.

While discouraging disclosure of the tests they have designed to catch fakers, national medical officers warned that few tricksters would escape.

The doctors will be on the lookout for men who pretend to be blind or deaf, men who take drugs to cause abnormal heart action, who put sand under their eyelids to cause inflammation, who take fake crutches, or those who pretend insanity or epilepsy.

Liberal Rules

Positive tests are available for eyesight and hearing. Conflicting statements and talkativeness give away many. However, some fakes are difficult to expose. Complaints of pain are most frequent. Hysteria often occurs and causes confusion.

Otherwise, doctors are instructed to be particularly careful in examining for defects of vision and hearing, abnormal thyroid gland conditions, mental and nervous deficiencies, valvular disease of the heart, emotional instability and defects of the feet.

They also are advised not to construe the rules "too strictly or arbitrarily," but at the same time to go beyond the regulations if necessary.

Meanwhile, officials hastened efforts to complete arrangements for drawing the numbers in the lottery.

A crew of six will start work Friday afternoon to put each of the 7,500 or more serial numbers in nontransparent capsules for the drawing.

On Monday, three crews of thirty will receive instructions for conducting the twelve- to fifteen-hour drawing after Secretary Stimson and other dignitaries have opened the lottery by selecting the early numbers.

Arrangements have been made for three unchangeable, permanent records of the order in which the numbers, to be used everywhere in determining when men will be called to service, are drawn in the lottery.

Master Number List

Each numbered slip taken from a capsule will be photographed on a strip of film and then attached with permanent cement to a master list. The list then will be photographed for reproduction and distribution to all draft boards. Both sets of photographs and the glued-up master list will be preserved in the national archives.—San Francisco *Call-Bulletin*, October 23, 1940.

COMMITTEE ON PUBLIC HEALTH EDUCATION†

Your Committee on Public Health Education has been greatly encouraged during the past month by the number of inquiries received from individual members of the California Medical Association asking for speech material to use before groups for talks either on the subject of state-controlled medicine or on other medical subjects. The Committee feels that this evidence of interest from various parts of the state indicates a growing realization of the necessity of informing the public of the advances in scientific medicine and the efforts of doctors of medicine to constantly better serve the public.

At the same time it should be pointed out that the Committee on Public Health Education has forwarded sets containing forty-nine speeches each, two of which are on the subject of state-controlled medicine, to the secretaries of county medical societies in the state, except in San Francisco, Los Angeles and San Diego counties, where the speeches were sent to the chairmen of the Speakers' Bureaus. The purpose was to make this speech material readily available to doctors of medicine who receive requests to make talks. These sets of speeches will be augmented during the next few months.

The Committee reports increased interest in the essay contest for students of high schools and junior colleges and students in private schools of comparable grades and in the motion picture scenario contest. Some of this interest was aroused by newspaper publicity, despite the difficulty of securing publicity at this time due to world conditions, and a large part of the increased interest in the scenario contest resulted from direct contact with the scenario writers by the Public Relations Counsel. Both of these contests close on November 15, after which judging will take place as quickly as possible.

Interesting results are expected from the experiment of providing medical literature for college students to explain the relative rôles of scientific medicine and those of various cultists. This experiment, started last spring, is being watched closely at Pomona, Scripps, and Claremont colleges with the entering freshman classes and the final report will be submitted within the next month. R. M.

† The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Phillip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Ilwaco; Lowell S. Goin, Los Angeles; Julius B. Harris, Sacramento; Harry H. Wllson (ex officio), Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUCKER 2312), or 244 Kearny Street, San Francisco (telephone YUKON 2212).

COMMITTEE ON POSTGRADUATE ACTIVITIES†

State Board of Public Health: In re Plan of Coöperation for Postgraduate Conferences

(Copy)

STATE OF CALIFORNIA

DEPARTMENT OF PUBLIC HEALTH

SACRAMENTO

October 3, 1940.

George H. Kress, M. D.
California Medical Association
450 Sutter Street
San Francisco, California

Dear Doctor Kress:

The State Board of Public Health is interested in postgraduate training for physicians, and would like to have a copy of the plan which has been adopted by the California Medical Association.

Would it be possible to furnish me with a copy of the proposed schedule for 1940 and 1941.

Very truly yours,

BERTRAM P. BROWN,
Director of Public Health.

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(Copy)

San Francisco, October 12, 1940.

Bertram P. Brown, M. D.
Director of Public Health
313 State Building
San Francisco, California

Dear Doctor Brown:

On my return from a series of visits to county medical societies in the southern section of the State, I find your letter of October 3.

Under separate cover, I am sending you the following:

Five-Year Program Outline of November, 1937

Five-Year Study Program of October, 1938

Pamphlet, "Suggestions to District and County Postgraduate Committees."

The Foreword and general information text in the October, 1938, Supplement of CALIFORNIA AND WESTERN MEDICINE outline the general plan of the courses that are offered.

The pamphlet indicates lines of possible approach.

A 1939 Supplement has not been printed because there has been no material change in the plan of organization or in the list of courses.

If your department has kept its file of CALIFORNIA AND WESTERN MEDICINE, you will find the references to postgraduate work in the semi-annual indexes which appear in the June and December issues.

Department 6 of the index has the caption, "California Medical Association Proceedings." Postgraduate reports are listed under the subheading, "Committee on Postgraduate Activities."

If you will refer to these reports you will be able to visualize somewhat the work we are trying to do.

May I express the hope that it will be possible for us to have a conference some time to talk over these matters? In the past we have availed ourselves generously of the

† Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

coöperation of the California Department of Public Health. The work can be greatly promoted if the Committee on Postgraduate Activities of the California Medical Association, and similar bureau of the California Department of Public Health and the four medical schools work hand in hand to develop a comprehensive program in our State.

I would be very happy to take this up with you at any time at your convenience.

If I can be of further service, feel free to inform me.

Cordially yours,

GEORGE H. KRESS,
Secretary, California Medical Association
Committee on Postgraduate Activities.

* * *

(Copy)

STATE OF CALIFORNIA
DEPARTMENT OF PUBLIC HEALTH
SACRAMENTO

October 15, 1940.

George H. Kress, M. D.

Secretary, California Medical Association
San Francisco, California

Dear Doctor Kress:

On my return to San Francisco, I find your letter of October 12, giving reference to the plan for postgraduate work of the California Medical Association.

The material, which you state is being sent under separate cover, will be read with interest.

I note, with genuine pleasure, in the closing paragraph of your letter your expression of a wish to have a conference at some time in the future. We, in the Department of Public Health, feel there is so much of mutual interest in a close working arrangement between the California Medical Association and the Health Department that I want to take this opportunity to assure you that I am personally very much interested in getting better acquainted with our mutual problems. There will undoubtedly occur times when the facilities of the State Department of Public Health can be of some aid in the solution of these problems. As soon as Dr. Amos Christie returns from the conference at Detroit, I will get in touch with you and arrange a time for the conference.

With kind personal regards, I am

Sincerely yours,

BERTRAM P. BROWN,
Director of Public Health.

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Tri-County Clinical Conference (Monterey, Santa Cruz, and San Benito)

Under sponsorship of Monterey County Medical Society, a tri-county clinical conference was held at Salinas and Hotel Del Monte. On October 3, in the afternoon, at Monterey County Hospital in Salinas, and in the evening, at Hotel Del Monte.

Program follows:

Part I. Afternoon Clinical Conference.—This was held at the Monterey County Hospital in Salinas, from the hours of 2 to 5 p. m., on Thursday, October 3.

The guest speakers were: Ludwig A. Emge and Charles F. Fluhmann of the Stanford Faculty, who discussed problems in obstetrics and gynecology in relation to patients presented. Doctor Fluhmann gave special attention to endocrine phases.

Part II. Dinner Meeting at Hotel Del Monte.—The dinner was held at 7 p. m. at Hotel Del Monte, after which Doctor Emge discussed the subject, "Toxemia in Pregnancy."

* * *

University of California Medical School to Give New Refresher Course

Plans for an intensive refresher course for physicians are now being made by the University of California Medical School, it was announced recently. The course, designed to acquaint practicing physicians with the progress of research during the past few years, will be held in Toland Hall, University of California Hospital, San Francisco, from January 6 to 8, 1941.

The program, dealing generally with the clinical aspects of dermatology, will include discussion of various common skin diseases, including tumors. Surgical aspects of dermatological problems will be considered and there will be lectures on infectious diseases.

The dean's office of the medical school will supply any physician with complete information about the course, on request, it was announced.

* * *

Clinico-Pathologic Conference in Contra Costa County

The Secretary of the California Medical Association Postgraduate Committee received the announcement of a Clinico-Pathologic Conference, conducted by the Contra Costa County Medical Society on October 8. The notice of the meeting is here reprinted for such suggestive value as it may have to committees of component county societies who may be wondering along what lines to present appealing programs:

(Copy)

CONTRA COSTA COUNTY MEDICAL SOCIETY CLINICO- PATHOLOGICAL CONFERENCE

Tuesday, October 8, 1940, 8 p. m.

("Dr." Charlie Chan, will you explain this case to me?)

The patient, a white male of forty years, well developed and well nourished, was admitted to the hospital on July 30 in a stuporous, semi-comatose condition.

Present Illness.—According to his wife, patient became ill four days previously, complaining of abdominal cramps localized chiefly in the epigastrium; he vomited once. The next day, subjectively better, he took fluids, but as his condition improved he ate a soft diet. Pain in his abdomen disappeared, but four days after onset of illness the patient became definitely worse, was restless, apprehensive, perspired freely, had a staring expression; and lapsed into a coma. He vomited once; there was no hemoptysis.

(Has a first impression formed itself in your mind?)

Physical Examination.—The patient was comatose on admission, opened his eyes only upon being violently shaken, did not answer questions or converse. Rectal temperature 98.6, pulse full, strong and regular; sweetish odor to the breath; perspiring freely. No contusions or lacerations of the head; face swarthy, slightly cyanotic, no muscular weakness. Pupils large, round, equal, fixed in mid-line, reacted to light; retinal vessels moderately tortuous, some AV notching, upper margins of discs blurred; conjunctivae injected, sclerae moderately chemotic. Lips dry and crusted; tongue in mid-line. Teeth dirty and carious; throat not visualized. No stiffness of neck, palpable thyroid or tracheal tug; moderate venous congestion in neck, marked carotid pulsation. Respirations 40 per minute, slightly irregular, shallow, noisy, semi-stertorous, drowning out breath sounds; chest resonant to percussion. PMI of heart 11½ cm. to left of MSL, rhythm regular, rate 90 per minute, tones forceful, no murmurs discerned. BP 120/80. Abdomen distended, tympanitic; no organs or masses palpable, no audible peristaltic sounds; no fluid or spasticity. External genitalia normal; rectal not done. Tendon reflexes present in upper extremities, absent to weak in lower extremities; abdominal and cremasteric reflexes absent; Babinski questionable bilaterally at first, later positive on right. Extremities without gross abnormality, edema, or evident weakness.

(Ready with your diagnosis? . . .)

Laboratory.—Urinalysis gave greenish-black color to Benedict's test, two plus acetone, no albumin; microscopically (centrifuged) 10 WBC/HDF, few red cells. WBC numbered 8,100, with PMN 12 per cent, Stab 55 per cent, Granulocytes 7 per cent, SL 26 per cent. Spinal fluid clear, pressure greater than 30 mm. of mercury. Blood sugar—after glucose solution intravenously—231 mgm. per cent.

Course.—Eight hundred c.c. of blood removed by phlebotomy; spinal fluid pressure reduced to normal levels by drainage; routine treatment for diabetic coma instituted. Except for gradual rise in temperature to 103.5, condition remained static for several hours. Then convulsive twitching of right side of face appeared, spread to entire face and then to entire body, clonic in character, resembling epileptic convulsions, with cyanosis, and lasted forty-five seconds. Then patient relaxed, seemed to breathe easier, and mumbled a few words indistinctly; his pulse gradually disappeared and, in spite of stimulants and oxygen administered, he expired about eight hours after entering the hospital.

(Now loosen your collar and put out your neck—
"My diagnosis is ———" then come to the Conference and see where the ax falls.)

* * *

Doctors at Work!

When doctor meets patient, drama begins. . . .

Doctors at Work in office, hospital, clinic—or at your bedside. Whenever or wherever you need them, doctors are ready.

Doctors at Work will be on the air, presented by the American Medical Association in coöperation with the National Broadcasting Company (Blue Network). On the air every Wednesday, 7:30 p. m. Pacific standard time, November 13, 1940 to June 4, 1941.

* * *

Sixth Annual Postgraduate Lecture Series: San Joaquin County Medical Society

The *Committee on Postgraduate Activities* of the San Joaquin County Medical Society, C. A. Broadus (Chairman), Samuel Hanson, John Eccleston, C. V. Thompson, Langley Collis, and A. L. Van Meter arranged the following program for the sixth annual postgraduate lecture series of the San Joaquin County Medical Society.

October 17 (Thursday evening at 8 o'clock). The meeting was held in the Medico-Dental clubrooms: (1) "Management of Abnormal Bleeding in Gynecologic Cases," by Dr. Daniel G. Morton; (2) "Management of Hemorrhage in the Last Trimester of Pregnancy," by Dr. Thomas Hayden.

October 24 (Thursday evening at 8 o'clock). Place of meeting, through the courtesy of Dr. William Friedberger and Doctor Barnes, was the San Joaquin General Hospital. Program: "A Medical Clinic." Conducted by Dr. William J. Kerr.

October 31 (Thursday evening at 8 o'clock). The meeting was held in the Medico-Dental clubrooms. Dr. Hans Lisser spoke on the topic, "The Fat and the Lean."

November 14 (Thursday evening at 8 o'clock). This is to be a joint meeting at St. Joseph's Hospital, in coöperation with the hospital staff). The subject, "Cancer of the Large Bowel," will be discussed by Dr. Robert Scarborough.

November 28 (probable date). Through the courtesy of Dr. William Friedberger and Dr. George Wever, it is hoped to have "A Medical Clinic" at the San Joaquin General Hospital, to be conducted by Dr. Dwight L. Wilbur.

December 19. Dinner at the Clark Hotel at 7 p. m. Dr. L. R. Chandler, Dean of the Stanford Medical College, will speak on the subject, "Intestinal Obstruction in Infants and Children."

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Abstract of Minutes of the Thirtieth Meeting of the Committee on Public Relations of the California Medical Association*

Held in San Francisco on Sunday, September 15, 1940, in the offices of the Association.

1. *Call to Order.*—The meeting was called to order by Chairman Donald Cass. Present were: Donald Cass, Chairman; Henry S. Rogers, President-Elect; Charles A. Dukes, Past President; Dwight L. Wilbur, Chairman of the Committee on Postgraduate Activities; George G. Reinle, Chairman of the Committee on Medical Defense; and George H. Kress, Association Secretary.

2. *Minutes.*—Minutes of the twenty-ninth meeting of the Committee were approved as previously circulated.

3. *Basic Science Law.*—Discussion of the fourth draft of the proposed basic science initiative law was had, Legal Counsel Peart informing the Committee that this draft incorporated all changes considered at previous meetings and minor modifications in legal phraseology.

A change was approved in the provision for reëxamination of applicants failing to make a 75 per cent grade in their examination.

The Committee voted to send a letter to the two state dental associations relative to their coöperation in the initiative campaign.

Discussion was had on the question of including a provision to permit amendments to the initiative law to be made by the legislature. Association Secretary Kress was instructed to check with the American Medical Association on whether other states with basic science laws had encountered much demand for amendment of their laws. It was agreed that if other laws had not been subject to much amendment it might be well to omit from the proposed initiative the provision for legislative amendment.

4. *House of Delegates' Resolution No. 30.*—House of Delegates' Resolution No. 30 (fees in county hospitals) as introduced at Coronado was considered. Plans in operation in Alameda County were discussed and agreement was had that these plans had much to commend them. Chairman Cass agreed to send in to the Council a supplementary report on this resolution.

5. *Resolution No. 14.*—Resolution No. 14 (expert testimony) was discussed and difficulties encountered in handling this situation were brought out.

Legal Counsel Peart estimated at \$500 the cost of obtaining copies of transcripts of testimony of members of the medical profession who appeared as experts in a number of subjects in court actions. It was felt that this approach to the problem might offer beneficial results, and Chairman Cass agreed to confer with authorities in the South and to make a later report.

6. *Adjournment.*

DONALD CASS, Chairman.

GEORGE H. KRESS, Secretary.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department. Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

* A complete copy of these minutes is available at the offices of the California Medical Association for inspection of all members.

CANCER COMMISSION OF THE CALIFORNIA MEDICAL ASSOCIATION†

A two-day conference on stomach cancer was held on October 11 and 12 at the National Cancer Institute of the National Institute of Health with an address by Dr. Thomas Parran, Surgeon-General of the United States Public Health Service.

This conference—the first of its kind in America—was sponsored by the National Advisory Cancer Council, headed by Surgeon-General Parran, and brought together leading physicians and scientists for an intensive consideration of research and clinical problems relating to the control of cancer of the stomach. It was called on the recommendation of the Cancer Council's committee on the coordination of cancer research and grants-in-aid, of which Dr. George M. Smith of Yale University is chairman.

Doctor Parran's address was followed by a discussion on cancer statistics and the hereditary and occupational aspects of gastric cancer. Dr. S. D. Collins, principal statistician of the National Institute of Health, United States Public Health Service, led the discussion and participants included Dr. C. C. Little of Bar Harbor, Maine, director of the Roscoe B. Jackson Memorial Laboratory, and Dr. Madge Thurlow Macklin of the University of Western Ontario Medical School, who discussed the hereditary aspects.

General participation on the part of all attending the conference followed the presentation of each subject.

The opening session also included a consideration of the importance of early diagnosis of cancer of the stomach and the various means of making these tests. A paper dealing with this subject was given by Dr. Rudolf Schindler of the University of Chicago, followed by a discussion led by Dr. James Ewing and Dr. Gordon McNeer of Memorial Hospital, New York, and Dr. Max M. Zininger of the University of Cincinnati.

At the afternoon session, Dr. Alexander Brunschwig of the University of Chicago presented a paper on the physiology and biochemistry of the stomach. Discussion was opened by Dr. A. C. Ivy of Northwestern University.

Experimental production of cancer of the stomach in test animals was also considered at the afternoon's meeting. Dr. Harold L. Stewart of the National Cancer Institute gave the principal paper, and his presentation was followed by a discussion opened by Dr. W. U. Gardner of Yale and Dr. Egon Lorenz and Dr. M. J. Shear of the National Cancer Institute.

Speakers at the October 12 session included Dr. C. P. Rhoads, Director of Memorial Hospital, New York, who reported on anemia and deficiency diseases in relation to cancer of the stomach; Dr. Mont R. Reid, professor of surgery, University of Cincinnati, who told how cancer clinic material can be used for investigations; and Dr. Carl Voegtlin, Chief of the National Cancer Institute, who conducted a discussion on a proposed program for the study of cancer of the stomach.

Other participants who took part included: Dr. Leon Schiff of the University of Cincinnati, Dr. John J. Morton of the University of Rochester, Dr. A. R. Dochez of Columbia, Dr. Walter C. Alvarez of the Mayo Foundation, Dr. Shields Warren of the Harvard Medical School, and Drs. M. C. Winternitz and A. W. Oughterson of the School of Medicine, Yale University.

All the sessions were held at the new National Cancer Institute building at the National Institute of Health near

Bethesda, Maryland. The cancer research laboratories, erected last year at a cost of \$750,000, are considered the most complete in the world, and participants in the conference were given an opportunity to inspect the laboratories and the cancer research work now in progress at the Institute.

CALIFORNIA PHYSICIANS' SERVICE†

MEMBERSHIP

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
October 15, 1940	17,915

Among groups enrolled during the month of September are the following: General Steamship Corporation, Los Angeles; G. F. Thomas Dyeing and Cleaning Works, San Francisco; Bertsch Machine Works, San Francisco; Snyder Brothers, Knitting Mills, San Francisco; Key System-Oakland Yard Office; Westinghouse Electric Co., Oakland; Mazor Brothers, Oakland; Schumacher Brothers, San Francisco; California Builders Supply Company, Oakland; City of Emeryville; Sprouse-Reitz Company, Lodi, Los Angeles and San Francisco; Shell Development, Emeryville; Belli and Belli, Florists, San Francisco; Talbot-Bird Company, San Francisco; American Vineyard Company, Fresno; San Mateo Feed and Fuel Company; Tonkin Distributing Company, San Francisco; Barriers' Club, San Francisco; American Radiator and Standard Sanitary Company; Wilson, Johnson & Higgins, San Francisco; Hood Rubber Company, San Francisco; National Lead Company, Oakland; United States Flexible Metallic Tubing Company, Los Angeles; Merchants' Association of Bakersfield; Kelite Products, Inc., Los Angeles; "H" & "S" Club, San Francisco; Myer-Siegel & Company, Los Angeles; Employees of Commercial Department, Pacific Telephone and Telegraph Company, Fresno; George W. Caswell Company, Oakland; Field-Ernst Company, San Francisco; Schloss Manufacturing Company, San Francisco; Cloverleaf Products Company, San Francisco; California State Automobile Association, Oakland; Galen Company, Berkeley; Shasta National Forest Administrative and Clerical Employees; Office Employees of Union Pacific Railroad Company, San Francisco; Family Service Agency, San Francisco; R. A. Shuey Creamery, Oakland; Office Staff, Mark Hopkins Hotel, San Francisco; Pacific Fruit Exchange, San Francisco; Employees of Maxwell House, Division of General Foods, Los Angeles; Cloverdale Elementary School; McLeod Mercantile Company, San Francisco.

† † †

Continuing the review of statistics discussed in recent issues, information is now available for the months of June and July.

JUNE

During the month of June, when there were 14,065 beneficiary members throughout the state, 1,993 cases were treated by 1,109 of the 5,097 professional members. Thirteen thousand seven hundred four dollars and eighty cents was disbursed to professional members in payment for 10,151.7 units of service rendered, at a unit value of

† Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. Alson Kilgore, M. D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization. For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

† For roster of members of the Cancer Commission of the California Medical Association, see page 2 in the front advertising section (bottom of the second column).

\$1.35. The average number of units of service rendered per doctor was 9.1, and the average check per doctor was \$12.36.

Among the 21.8 per cent of the professional members throughout the state who participated during the month of June, the distribution of patients by doctors was as follows:

681 doctors saw	1 patient each
224 doctors saw	2 patients each
106 doctors saw	3 patients each
35 doctors saw	4 patients each
22 doctors saw	5 patients each
19 doctors saw	6 patients each
10 doctors saw	7 patients each
5 doctors saw	8 patients each
4 doctors saw	9 patients each
2 doctors saw	11 patients each
1 doctor saw	14 patients

The average number of visits per case was 2.92, and the average number of units per case was 5.09.

JULY

There were 15,608 dues-paying members throughout the state during July, out of which there were 2,219 cases treated by 1,199 professional members, representing 23.5 per cent of all professional members in the state. There were 11,073.5 units of service rendered, for which \$14,948.23 was disbursed, at a unit value of \$1.35. The average number of units of service rendered per doctor was 9.2 and the average check per doctor, \$12.47.

The distribution of patients among doctors throughout the state was as follows:

706 doctors saw	1 patient each
264 doctors saw	2 patients each
120 doctors saw	3 patients each
39 doctors saw	4 patients each
28 doctors saw	5 patients each
15 doctors saw	6 patients each
9 doctors saw	7 patients each
4 doctors saw	8 patients each
7 doctors saw	9 patients each
4 doctors saw	10 patients each
1 doctor saw	12 patients
1 doctor saw	14 patients
1 doctor saw	15 patients

The average number of visits per case was 2.17, and the average number of units per case was 4.99.

Unit value for the month of August was established at \$1.35. During the months of June, July, and August there was available for medical service payments, \$52,112.98. Out of this sum, \$7,415.80 has been set aside as a reserve to stabilize the value of the unit during the winter months when we can expect heavy demands upon the service.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (21)

Alameda County (1)

David Singman, *Berkeley*

Kings County (1)

Alberta R. Bassett, *Hanford*

† For roster of officers of component county medical societies, see page 4 in front advertising section.

Concerning absence in this issue of letters from county societies, see comment in October 1940 issue, on page 154.

Marin County (1)

Leonard H. Larsen, *San Rafael*

Mendocino County (1)

Louise E. Petty, *Talmage*

Placer County (1)

Arthur William McArthur, *Lincoln*

San Diego County (3)

Ruth Harmon Ray, *San Diego*

Allen M. Walcott, *San Diego*

Homer R. Wolfson, *La Mesa*

San Francisco County (7)

Henry Marvin Hodgson, *San Francisco*

Francis Marion Jacks, *San Francisco*

George P. Lyman, *San Francisco*

Lowell A. Rantz, *San Francisco*

Donald R. Smith, *San Francisco*

Robert P. Watkins, *San Francisco*

Helen B. S. Weyrauch, *San Francisco*

San Joaquin County (1)

Robert Dyar, *Stockton*

Santa Barbara County (2)

J. L. Kalfus, *Santa Maria*

Thelma Perozzi, *Santa Barbara*

Santa Clara County (3)

Marguerite De Cola, *San Jose*

Ernest Hockenbeamer, *San Jose*

Dorothy Starks, *Palo Alto*

Transfers (5)

L. P. Borden, from Alameda County to Santa Clara County.

Mark Gerstle, Jr., from San Francisco County to Santa Clara County.

Henry Lane, from San Francisco County to Santa Clara County.

Edward Maher, from San Luis Obispo County to Santa Clara County.

Elmer W. Smith, from Marin County to San Joaquin County.

Resigned (1)

Josephine Jackson, from Los Angeles County.

In Memoriam

Cochran, Guy Hunt. Died at Los Angeles, October 7, 1940, age 67. Graduate of Columbia University College of Physicians and Surgeons, New York, 1900. Licensed in California in 1903. Doctor Cochran was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Shulman, Leon. Died at Los Angeles, September 14, 1940, age 55. Graduate of the University of California Medical School, Berkeley, 1911, and licensed in California the same year. Doctor Shulman was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

+

Taylor, Robert Beverly. Died at San Francisco, September 15, 1940, age 36. Graduate of Creighton Uni-

versity School of Medicine, Omaha, 1933, and licensed in California the same year. Doctor Taylor was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Zeller, Ward Clifton. Died at Visalia, September 26, 1940, age 66. Graduate of Ohio Medical University, Columbus, Ohio, 1897. Licensed in California in 1920. Doctor Zeller was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✦

OBITUARY

Leon Shulman

1885-1940

The recent death at Los Angeles of Dr. Leon Shulman brings to an end the long service of the founder of the Jewish Consumptive and Ex-Patients Relief Association.

Doctor Shulman was born in France fifty-five years ago and received his degree from the University of California in 1911. He taught medicine at the University of Southern California from 1913 to 1919 and during the World War served as tuberculosis specialist at Camp Kearney. He had been chairman of the Board of Los Angeles Sanatorium since its establishment.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN.....Asst. Chairman on Publicity

Alameda County opened the fall season with a reception at the Claremont Country Club, Dr. Gertrude Moore being the honored guest.

✧

The Fresno County Auxiliary has been approached by the local Junior Chamber of Commerce to help in establishing an abatement district for mosquito control. The same Auxiliary has formed a committee for allied relief.

✧

Mrs. H. W. Comfort of Fortuna entertained eighteen members of the Humboldt County Auxiliary.

✧

Los Angeles County boasts of an attendance of one hundred members on September 24, when Mrs. Robert Millikan's talk, entitled "Trailing a Scientist Through India," was thoroughly enjoyed. Mrs. William C. Boeck gave an account of the State Board meeting in Alameda County.

✧

Dr. Norris R. Jones, President of the Sacramento County Medical Society, complimented forty members of its Auxiliary on the splendid work accomplished during the past year.

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 2435 Nottingham Avenue, Los Angeles. Address of the Chairman on Publicity: Mrs. William C. Boeck, 712 North Maple Drive, Beverly Hills.

For roster of officers of state and county auxiliaries, see advertising page 6.

That excellently organized and active Auxiliary in San Diego County plans to meet on the second Tuesday of each month. Health Education will be stressed by the membership this year, arrangements having already been made to place speakers on medical topics before the Girl Scouts, the Girl Reserves, the Boy Scouts, the Campfire Girls, and the Parent-Teacher groups. Speakers will address adolescent boys, adolescent girls, and a mixed group of adults at "Neighborhood House." Work is well under way on the survey being conducted by the Public Relations Committee, of which Mrs. Wilton Lewis is chairman, which will produce a valuable index system of the various organizations in San Diego. Over 225 organizations have been contacted and information obtained as to the number of members, whether or not they have a health program and whether or not they would desire or permit speakers to appear before them. The Auxiliary is also sponsoring a scholarship loan to assist worthy students in paying their expenses in medical schools.

✧

The San Francisco membership has decided to assist the British War Relief by giving a fashion talk and demonstration, the proceeds to supply medicine to the children of the British War Relief. Mrs. Eugene Kilgore and Mrs. Raleigh W. Burlingame were appointed chairmen of the event. Moneys recently raised for the Scholarship Fund have been sent to the Universities of Stanford and California.

✧

Ruth Comfort Mitchell (Mrs. Sanborn Young), gave the Santa Clara membership an interesting account of her trip to the Republican National Convention in Philadelphia. Approximately seventy members and guests were present.

✧

Mrs. A. J. Pederson will preside at the Santa Cruz meetings this year.

✧

The Solano County Auxiliary is eagerly looking forward to a visit from State President Mrs. A. E. Anderson on November 12. Extensive plans are being made to entertain her.

✧

Mrs. W. N. Steele, Jr., reports that the Stanislaus Auxiliary is embarking on a new project. It deals with occupational therapy for tuberculous patients at the County Hospital. The membership will give financial and moral support, as well as help to collect materials with which to work and will distribute the finished products.

The Eskimo population of the Western Canadian Arctic is showing a distinct and dangerous decline from tuberculosis and other diseases of the white man. The Rev. H. R. Rokey-Thomas, an Anglican missionary who has spent five years in a parish on Victoria Island which extends up into the neighborhood of the North Pole, has under his care 750 Eskimos of whom 70 per cent are ill with tuberculosis in varying stages. "There is certainly a definite down-trend in population, in my parish at least," says the missionary, "and that probably is true of other parts of the Western Arctic." He suggests that the provision of medical care and hospitals might go far toward solving the problem, but many obstacles would have to be faced and the cost would be heavy. Transportation would always be a problem but he is convinced that something should be done before Canada finds her Eskimo population shrunk to a pitiful remnant of its former thousands.—*Contact*, November, 1939.

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 5-8, 1941.

American Medical Association, Cleveland, Ohio, June 2-6, 1941.

American College of Physicians, Statler Hotel, Boston, April 21-25, 1941.

American College of Surgeons, Chicago, October 21-25, 1940.

Medical Broadcasts.*

American Medical Association Series of Radio Programs: Every Wednesday, 7:30 p. m., Pacific Time, Over Blue Network.—*Doctors at Work* is the title of the sixth annual series of dramatized radio programs to be presented by the American Medical Association and the National Broadcasting Company.

The series will open on Wednesday, November 13, 1940, and run for thirty consecutive weeks, closing with a broadcast from the American Medical Association meeting at Cleveland on June 3, 1941. The program is scheduled for 10:30 p. m., Eastern standard time (9:30, Central; 8:30, Mountain; 7:30, Pacific time) over the Blue Network, other NBC stations, and Canadian stations.

The programs will dramatize what modern medicine offers the individual in the way of opportunities for better health and the more successful treatment of disease. Incidental to this main theme, the programs will explain the characteristics of the different fields of modern medicine and its specialties.

"Doctors at Work" will be broadcast from scripts by William J. Murphy, NBC script writer and author of many previous American Medical Association and NBC "shows" and other popular radio features. It will be produced under the direction of J. Clinton Stanley, director of "Medicine in the News," last season's successful American Medical Association and NBC health program. Supervision will be by the American Medical Association Bureau of Health Education, directed by Dr. W. W. Bauer.

Descriptive posters for local distribution may be had gratis from the Bureau of Health Education, American Medical Association, 535 North Dearborn Street, Chicago. Program titles will be announced weekly in *The Journal of the American Medical Association*, and monthly in *Hygeia, the Health Magazine*.

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical

† In the front advertising section of *The Journal of the American Medical Association*, a different roster of national officers and organizations appears each week, each list being printed in revised form about every fourth week.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KEX	Portland
KFSD	San Diego	KJR	Seattle
KGO	San Francisco	KTMS	Santa Barbara
		KGA	Spokane

1 1 1

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of November is as follows:

Saturday, November 2—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, November 6—KECA, 11:15 a. m., The Road of Health.

Saturday, November 9—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, November 13—KECA, 11:15 a. m., The Road of Health.

Saturday, November 16—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, November 20—KECA, 11:15 a. m., The Road of Health.

Saturday, November 23—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Wednesday, November 27—KECA, 11:15 a. m., The Road of Health.

Saturday, November 30—KFI, 9:45 a. m., The Road of Health; KFAC, 10:15 a. m., Your Doctor and You.

Postgraduate Symposium on Heart Disease: San Francisco Heart Committee.—The eleventh annual Postgraduate Symposium on Heart Disease by the San Francisco Heart Committee will be held in San Francisco on November 26, 27, and 28, 1940, as follows:

Tuesday, November 26—Morning and afternoon clinical sessions will be held at Stanford University Hospital. The evening session, covering technical demonstrations, will be held at the University of California Hospital.

Wednesday, November 27—Morning and afternoon clinical sessions will be held at the University of California Hospital.

Morning and afternoon public health sessions will be held at Mount Zion Hospital.

On Wednesday evening the annual dinner will be held, to which all those who are interested in the problems of heart disease prevention are invited. The speaker of the evening will be Chauncey D. Leake, Ph. D., Professor of Pharmacology, University of California Medical School. The subject will be "Harvey, the Heart, and War." A musical program will also be presented.

Thursday, November 28—Morning and afternoon clinical sessions will be held at the San Francisco Hospital.

A copy of the program and information regarding registration fees and other particulars may be obtained by writing to Dr. Richard D. Friedlander, Program Chairman, San Francisco Heart Committee, 604 Mission Street, Room 802, San Francisco.

Bovine Tuberculosis Conquered.—All but two counties in California are now free from bovine tuberculosis and these two counties will have their final test in December. In January, the United States will be free from bovine tuberculosis.

Dust Studies Undertaken.—At the request of the Bureau of Reclamation, United States Department of the Interior, arrangements have been made by the State Board of Health of California to conduct medical, engineering, and chemical investigations of the health hazards involved in the inhalation of pumicite dust during the excavation of this material for use in the construction of the Friant dam.

Lectures at Huntington Memorial Hospital, Pasadena: Physicians Invited.—The Board of Trustees of the Collis P. and Howard Huntington Memorial Hospital presents a series of three lectures by Dr. Walter C. Alvarez, consulting physician in the Division of Medicine at the Mayo Clinic, professor of medicine at the University of Minnesota (Mayo Foundation), and formerly professor of medicine at the University of California.

These lectures will be given in Culbertson Hall at the California Institute of Technology at eight o'clock in the evening. (Culbertson Hall is located on the corner of Wilson Avenue and East California Street, Pasadena.)

The dates and subjects are as follows: Wednesday, October 30, Abdominal Pain; Thursday, October 31, Peptic Ulcer; and Friday, November 1, Why a Nervous Break-down?

Southern California Medical Association.—The Southern California Medical Association will hold its 103rd semi-annual meeting on Friday and Saturday, November 15 and 16, 1940, at the California Hotel, San Bernardino. An exceptionally fine program has been arranged which will include subjects of sufficient general interest to be of value to the specialist and general practitioner alike.

The Association is fortunate in having secured two fine guest speakers for this meeting. Dr. Thomas Addis, Professor of Medicine at Stanford University, will address the Association on the "Treatment of Nephritis." Dr. Frederick L. Reichert, Professor of Surgery at Stanford University, will discuss the problem of "Circulatory Disturbances in the Upper and Lower Extremities." The program will include, in addition to several papers of general interest, two symposia; one on "The Present Status of Hypertension," and the other on "Non-Malignant Diseases of the Colon."

The forthcoming meeting will, in addition to broadening our scientific knowledge, give us an opportunity to renew old friendships and make new acquaintances.

Officers for 1940: John B. Doyle, president, Los Angeles; Watie M. Alberty, first vice-president, San Diego; Ray B. McCarthy, second vice-president, Riverside; Edward W. Boland, secretary-treasurer, Los Angeles.

Councilors are: Robert W. Langley, Los Angeles; Merrill W. Hollingsworth, Santa Ana; William H. Barrow, San Diego; John C. Ruddock, Los Angeles; John B. Doyle, ex officio; Edward W. Boland, ex officio.

Board of Governors for 1940 include: F. M. Pottenger, Los Angeles; Egerton L. Crispin, Los Angeles; Joseph K. Swindt, Pomona; Charles T. Sturgeon, Los Angeles; Paul E. Simonds, Riverside; Raymond G. Taylor, Los Angeles; Fred B. Clarke, Long Beach; Carl R. Howson, Los Angeles; Bon O. Adams, Riverside; H. Douglas Eaton, Los Angeles; and Frank R. Nuzum, Santa Barbara.

Programs of the meetings may be secured from the secretary, Edward W. Boland, M. D., 2202 West Third Street, Los Angeles.

Laboratory Infections.—During August two cases of pneumonia occurred in the personnel of the research laboratory conducted by the State Department of Public Health in Berkeley. Both workers were critically ill with what is without a doubt a virus type of pneumonia, and as they were working with such viruses in the laboratory the infections were without doubt contracted there.

Latest Air-Raid Precautions Included in Building Red Cross-Harvard Hospital.—The American Red Cross-Harvard Hospital—a prefabricated 100-bed unit to be set up in England for the study of wartime epidemics under "siege" conditions—will be equipped with air-raid shelters, a score of shatterproof features, and a special camouflage against enemy air raiders. . . .

The hospital will consist of twenty buildings, Mr. Smith said. Plans call for using a special five-ply building board with an insulating core sandwiched between fire-resistant sheets. This will be bolted to a structural steel framework. Each unit will be painted to match the surrounding terrain as a camouflage.

At the end of each unit will be a vestibule arrangement to allow doctors and nurses to enter and leave without light escaping. Windows will consist of three parts: a shutter for blackouts, a special window of nonshatter celoglass, and a screen.

Ventilation experts in this country are devising means of circulating fresh air through the buildings while closed during blackouts. The ventilation system will include filters between wards as a precaution against transmitting disease germs. . . .

Results of the survey will be reported by the Red Cross and Harvard to the United States Public Health Service and the Surgeon-General of the Army and Navy.

Industrial Physicians and Employers to Convene on November 14.—Industrial physicians and manufacturers from all over the country will attend the American Conference on Industrial Health to be held on Thursday, November 14, at the Towers Club in Chicago. The conference will be sponsored by the American Association of Industrial Physicians and Surgeons, a 25-year-old organization.

This first meeting of the American Conference on Industrial Health has for its purpose the correlation of viewpoints of all persons who are interested in promoting industrial health. These include the employer, physician, industrial hygienist, labor, psychiatrist, insurance companies, public relations men, safety expert, and the legal profession.

Dr. Clarence O. Sappington of Chicago, well-known consulting industrial hygienist, and co-chairman of the committee with Dr. Edward C. Holmblad, stated: "We have invited the manufacturer and other persons to attend and participate in the convention so that we may prove the practical value and application of industrial health work, and so that they may realize how much time and money may be saved yearly by such measures."

Among the prominent speakers who will talk at the convention sessions are: Dr. Morris Fishbein, editor of *The Journal of the American Association*; B. C. Heacock, president of the Caterpillar Tractor Company of Peoria; Dr. Volney S. Cheney, medical director of Armour and Company; and J. M. Conway, representing the National Association of Manufacturers, New York.

The conference, which is scheduled to begin at 9:30 a. m., will conclude with a dinner session at which Doctor Fishbein and Mr. Conway will speak.

Migrant Problem in Southwest.—The National Tuberculosis Association has called a meeting of the Tuberculosis Secretaries of the Southwestern States at Santa Fe on October 28 and 29 for discussion of the migrant problem. Others interested in this problem in the Southwestern States have been invited to participate. The discussion will center around the "special measures needed to reduce the death rate in the high death rate states."

The meeting is timely following as it does the recent hearings of the Tolan Committee in San Francisco and preceding the announcement of the Tolan Committee report.

During the San Francisco hearings of the Tolan Congressional Committee the California Tuberculosis Association filed a brief setting forth four conclusions:

1. The migrant problem is almost unapproachable until uniform settlement laws are established in all states.
2. Provision should be made for medical and hospital care of transients found to have tuberculosis or other disease which might be communicated to residents of the states.
3. The Social Security policy of giving grants in aid to counties for maintenance of full-time health units should be continued.
4. There should be established a program of relief for migrants, details of such program to be sought from experts in that field.

Northwestern University Medical School.—Eighty fledgling doctors are among the students who are "living high" at Northwestern University this year in the new twenty-story Abbott Hall, believed to be the tallest building in the world used exclusively as a university dormitory.

Housing 850 students on the University's Chicago campus, where the medical and dental schools and the school of law are located, the new building is 210 feet tall and cost more than \$1,750,000.

It is a city in itself, with shops, libraries, dining rooms, lounges, exercise facilities including bowling alleys and squash courts, and a recreational roof garden at the tenth-floor level. Across Lake Shore Drive is a new sand beach on Lake Michigan.

The building itself is L-shaped and is modified Gothic in style. It is built of Indiana limestone to conform with other buildings on the campus. Abbott Hall contains 2,200,000 cubic feet and is of completely fireproof construction.

The building was named for Wallace C. Abbott, founder of Abbott Laboratories, and his wife, Clara A. Abbott, from whose estate Northwestern University received last December a gift of \$1,500,000 for use in medical, chemical, and surgical research.

Students in the medical school will live on the sixth, seventh, eighth, and ninth floors of Abbott Hall. Each residential floor accommodates fifty-six students and has two shower rooms, two lavatories, and a large lounge facing toward the lake.

Arrangements permit members of the fifteen fraternities which had occupied temporary residences near the campus to have a floor, or a part of a floor, for their exclusive use. Among fraternities using the building's facilities are several medical groups. The dormitory relieves congestion in near north side housing for some of the 1,200 students enrolled in the University's professional schools.

The skyscraper dormitory is the eighth structure on Northwestern University's Chicago campus, where the professional schools and the evening departments are located. In 1924, Mrs. Montgomery Ward gave more than \$8,000,000 to build and endow the Ward Memorial building, which houses the classrooms and clinics of the medical and dental schools. . . .

Tuberculosis Statistics for California Counties.—The California Tuberculosis Association (45 Second Street, San Francisco) has brought off the press an interesting analysis of tuberculosis morbidity and mortality, in relation to California's counties. Copies of the table may be obtained from the Association for 15 cents each, postage prepaid.

Conjunctivitis Among Welders.—During the past year 746 cases of conjunctivitis among welders were reported in California, which number constitutes 13 per cent of all occupational diseases reported. The hazard is important since it can be prevented by wearing goggles or helmets fitted with glass of proper shade to filter out the injurious ultra-violet rays from the welding arc or torch.

Psittacosis Control.—During the month of August, 168 interstate shipping certificates were issued by the State Board of Public Health of California for 2,678 shell parakeets and 204 larger psittacine birds. Also, ninety-eight shell parakeet aviary inspections were made.

A fatal case in Long Beach was investigated. The patient was a pet shop operator. Postmortem tissue was found to be positive for psittacosis, also three shell parakeets in her pet shop were infected. One of these birds was actively shedding the virus in nasal discharges.

Advances in Treating Syphilis.—Recent advances in methods of treating syphilis will be described to practicing physicians in a postgraduate course to be given here on January 6 to 8, 1941, by the University of California Medical School.

The course, designed to acquaint practicing physicians with newest research developments in various fields of dermatology, will deal with the principles of treatment in early, latent and late syphilis; fever therapy as an adjunct in the treatment of neurosyphilis and the newly developed "five-day" treatment now undergoing clinical tests at Mount Sinai Hospital in New York.

Other research developments to be covered in the three-day course will concern precancerous skin conditions; vitamin treatment of skin disease; immunization for poison oak and allergy in dermatology.

A complete program will be sent by the Dean's Office of the University of California Medical School, San Francisco, to any physician interested.

Scientists Warn on Plane-Carried Mosquitoes.—Development of more effective control measures is needed to insure against epidemics that may be started by airplane transport of disease-carrying mosquitoes to uninfected parts of the world.

This is a warning voiced in a new book, "Mosquito Control," written by Dr. William B. Herms of the University of California College of Agriculture, and Harold F. Gray, consulting civil engineer. The book was published by the Commonwealth Fund of New York.

The scientists point out that the dangers of infecting uninfected areas has been increased with airplanes making extensive trips within a few hours or days. Even in earlier times slow-moving sailing ships, where breeding en route was possible, were known to have introduced mosquitoes into isolated islands such as Hawaii.

An epidemic might be started in one of the southern cities of the United States by transport of a yellow-fever bearing species from a South American airport, Doctor Herms and Gray write.

They added that transport of a malaria-carrying species from California to Hawaii, where the disease was un-

known, by a Pan-American Airways clipper plane, ultimately may become both a public health and an economic disaster to the Islands.

Pointing out that spraying en route with possibly inflammable and toxic sprays is both dangerous and irritating to passengers, the scientists said the following steps should be taken:

Rigid control measures within a half-mile radius of airports should be instituted; special screened double-door embarkation vestibules for passengers should be used; planes should be mosquito-proofed so far as possible; a new spray, highly toxic for mosquitoes but nontoxic for humans, noninflammable, nonexplosive, and free of oily residue should be developed.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Medical Lectures to Open

Opening lectures in a new series of public medical discussions sponsored by the Los Angeles County Medical Association will be held at 8 p. m. today in the El Rodeo School auditorium at Wilshire Boulevard and Whittier Drive, Beverly Hills.

Tonight's program will include a historical review of "Medicine Through the Ages" by Stanley K. Cochems, executive secretary of the Los Angeles County Medical Association. Dr. Lowell S. Goin will speak on cancer, giving a general survey, facts and fallacies of the disease.

Preliminary discussions concerning general medical education in Los Angeles County and the State will be presented by Dr. Harry H. Wilson, president of the California Medical Association, and Dr. Roy E. Thomas, president of the county association.—Los Angeles Times, October 15.

* * *

Use of Insurance Company Doctors as Impartial Medical Examiners Scored

San Francisco.—The legal department of the California State Federation of Labor took direct issue last week with the State Industrial Accident Commission over the commission's practice of referring injured workers to insurance company doctors for examination. The federation objected to the use of such doctors as impartial medical examiners.

In a letter to the commission concerning the case of an injured union carpenter from Oakland, named Pallister, the federation legal department informed the State Industrial Accident Commission that it had instructed Pallister to ignore the commission's order for him to report to an insurance company doctor for examination.

"It is a matter of common knowledge," the letter said, "that the doctor in question receives a large part of his income from insurance companies. . . .

"We felt, under the circumstances, that this doctor should not be appointed as an impartial medical examiner in this case or in any other case. We feel that even though he is not consciously prejudiced against an injured worker and in favor of an employer, or insurance carrier, his position would unconsciously prejudice him and affect any opinion he might render as to the right of the injured worker to collect an award of compensation."—Fresno Labor News, September 27.

* * *

Medical Care of Workers Scored

American Federation of Labor Asks Correction of "Abuses" Under Compensation Law

By Al T. Baum

Labor Editor, *The Examiner*

Long brewing friction between organized labor, principally building trades unions, and the State Industrial Accident Commission over asserted abuses in connection with medical attention accorded injured workers under provisions of the workmen's compensation act broke into the open yesterday.

Acting in accordance with a number of resolutions adopted by the Santa Monica convention last month, the legal department of the State Federation of Labor announced a list of demands for "correction of abuses" which will be presented to the State Industrial Commission.

Chief Objections

Main points of objection by the federation include:

1. Use of doctors under salary from insurance companies to treat injured workers and advise on the extent of their injuries.

2. Use of doctors under contract with insurance companies to treat injured workers and advise on the extent of their injuries.

3. Favoritism by the State fund in the selection of doctors.

A prepared statement from local federation headquarters declares that "it is obvious" that a physician depending upon an insurance company for a salary is "not a free agent" and that workers treated by such physicians are often denied proper medical attention "because of the cost."

Fee Policy Charged

Contract doctors, the statement continues, usually work for insurance companies under contracts which give them a percentage of the gross insurance written by the companies in their territories. "The less medical service furnished, the more the doctors make," it is charged.

The following suggestion was offered by the State Federation:

"Establishment of panels in every section of competent industrial surgeons to be prepared by a committee composed of representatives from the University of California and Stanford medical schools, various county medical societies, State industrial accident commission and the State Federation of Labor.—San Francisco Examiner, October 17.

* * *

Pay Ward Sought at Tulare Hospital

Tulare (Exclusive).—The Tulare County Farm Bureau and Grange today started circulation of petitions asking the county to provide a pay ward at the County Hospital here, to permit treatment of pay patients as well as charity patients.

The petition suggests a ceiling of 5 cents increase in the tax rate for the project. This would raise \$40,000 for the pay wing, Chairman Joe Hill of the Farm Bureau Hospitalization Committee said.—Los Angeles Times, October 4.

* * *

American Medical Association Library

The library of the American Medical Association, which ordinarily receives 1,400 periodicals, reports that medical literature from Europe is scarce these days.—Hanford Journal, September 29.

* * *

High-Lights of High School Happenings

An essay contest, sponsored by the California Medical Association for students in California high schools and junior colleges has been approved by the State Department of Education. "The Role of Doctor of Medicine in the Life and Health of the American Citizen," is the contest title.

Prizes will be of \$100, first; \$50, second; \$25, third; and five prizes of \$5.00 each, accompanied by an appropriate certificate. The essays are to be original works of 3,000 words.

The contest is scheduled to close November 15 with awards being made about December 15.—Eureka Standard, October 4.

* * *

Pay-Hour Law Change

Act Revised to Exempt White Collar Workers Making \$200 per Month: Professional Employees

Washington (AP).—The wage-hour administration revised its rules today for the exemption of "white collar" workers from hours restrictions of the labor standards law, established a \$200 monthly salary as one yardstick for determining who is an exempt administrative or professional employee.

The new rules go into effect October 24 when forty hours becomes the standard work week for all workers covered by the act. The present maximum work week without overtime pay is forty-two hours.

Altogether, the administration made changes affecting its definitions of executive, administrative and professional employees, retail trade workers and outside salesmen. . . .

An Executive and Administrator Defined

In revising the definitions, the administration at the outset made separate classifications for "executive" and "administrative" which heretofore have been included under one definition.

An executive was defined broadly as an employee who has management duties and power to hire or fire, is paid at least \$30 a week, and does no more than 20 per cent of the kind of work performed by nonexempt employees. If he does more than 20 per cent nonexempt work, he would be classified as a working foreman and entitled to overtime pay.

An exempted administrative worker was defined as one who is engaged under only general supervision in non-manual work related directly to management policies or general business operations which require the exercise of discretion and independent judgment, and who receives \$200 a month or more.

Rules Governing the Professional Worker

An exempted professional employee (other than a doctor or lawyer) was defined as one receiving \$200 a month or over, whose work is predominantly intellectual and varied in character, whose product cannot be standardized, and which requires "knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study, as distinguished from a general academic education" or is "predominantly original and creative in character in a recognized field of artistic endeavor." . . .

Exempted Worker Must Be Originator

In explaining the \$200 basis for exemption of administrative and professional employees, Harold Stein, hearing officer whose recommendations formed the basis for the revised rules, said that the payment of a salary commensurate with the duties of an administrative worker appeared to be the most effective check on the validity of a claim for exemption.

He expressed the view that titles alone were cheap, and asserted that a janitor should not be removed from the coverage of the act by merely calling him a "superintendent of maintenance." . . .—*San Francisco Chronicle*, October 14.

* * *

54,984 from Ninth Corps Area Will Be Called in Draft

Washington (AP).—National draft headquarters' lists, announcing the number of men to be drafted for military service from each Army Corps Area during the next year, disclosed today that the Ninth Corps Area, including California, Idaho, Montana, Nevada, Oregon, Utah, Washington and Wyoming, will provide 54,984. . . .—*San Francisco Examiner*, October 19, 1940.

* * *

Doctors Want Essays on Their Merits

Doctors of medicine in California are reversing their usual rôle by seeking advice from their patients.

Through the Committee on Public Health Education of the California Medical Association, the physicians are inviting essays on "The Rôle of the Doctor of Medicine in the Life and Health of the American Citizen," and asking junior college and high school students to give their views by November 15.

All residents of California are being invited to give their views on the progress of scientific medicine through a scenario contest, the winning scenario to be the theme of a motion picture to be produced by the doctors' committee. Both contests carry suitable prizes for winners.

Headquarters of the California Medical Association at 450 Sutter Street, San Francisco, will advise anyone inquiring about these projects and how the doctors hope to use the answers to enable the medical profession to better serve the public.—*Woodlake Echo*, September 27.

* * *

Medical Men Ask Essays and Scenarios from All Students

The California Medical Association is seeking advice from member patients. They are asking junior college and high school students to write an essay on "The Rôle of the Doctor of Medicine in the Life and Health of the American Citizen," by November 15.

They are also inviting a scenario to be written, and the winning one will be the theme of a motion picture.—*San Rafael Journal*, October 3, 1940.

* * *

Contest Sponsored by Medical Group

The State Medical Association is sponsoring an essay contest, open to students of the tenth, eleventh and twelfth grades and junior college, the topic being "The Rôle of the Doctor of Medicine in the Life and Health of the American Citizen." Several local students are planning to enter the competition, according to word from the high school and college.

Although the essays must be original, free use of appropriate references will be allowed in preparing the 3,000 words, it was explained. The contest ends November 15, and the awards will be announced in December.—*Santa Maria Times*, October 3.

* * *

Los Angeles County Fair

Pomona to Welcome First of Expected 750,000 Sightseers

Pomona, Sept. 12 (Exclusive).—Los Angeles County's nineteenth annual fair opens its gates tomorrow on its 1940 "American Pattern for Peace" in a seventeen-day exposition which Secretary-Manager C. B. Afferbaugh predicts will be a most successful reflection of the Southland's vast assets.

Three hundred landscaped acres have been made ready for the expected 750,000 persons who will view some 15,000 individual exhibits. . . .—*Los Angeles Times*, September 13.

Doctors to Greet Three State Officers at Dinner

Members of the Riverside County Medical Society and their wives will join those of the San Bernardino County group at a dinner honoring three officers of the California Medical Association Tuesday at Mapes Cafeteria in San Bernardino at 7 p. m.

Brief addresses will be made by Dr. Henry S. Rogers of Petaluma, President-elect of the California Medical Association; Dr. George H. Kress of San Francisco, Secretary, and Dr. S. J. McClendon of San Diego, delegate at large, and Dr. C. L. Emmons, Ontario.

Dr. T. A. Card, President, will lead the Riverside County group, which will include Dr. W. W. Roblee, past State President. This event will replace the October meeting of the local doctors' organization.—*Riverside Enterprise*, October 4.

* * *

Health Administration Change Opposed by County Officer Pomeroy Declares Recommendation of United States Survey to Invoke Old State Law Impractical

A recommendation made in the United States public health survey of the Los Angeles City Health Department that use be made in this area of the California local health district law is censured in the annual report of County Health Officer J. L. Pomeroy, filed yesterday with the Board of Supervisors.

Doctor Pomeroy calls attention to the fact that the County Health Department studied and considered the use of the California act twenty years ago and that it was rejected because of serious defects which rendered it inapplicable to a metropolitan district. Among these he cited:

1. The law provides for the creation of an independent governing body with power to levy additional taxes up to 15 cents on each \$100 of assessed valuation, over and above all other taxes.
2. That public health would be thrust directly into politics, because there is no provision made for the adoption of civil service.
3. That there is no provision for social security such as retirement, disability, etc.
4. That the governing body would be independent of the Board of Supervisors and would consist of one representative of each of the incorporated cities and rural districts, thus providing the possibility of the governing body having a huge membership, approximately forty-seven persons.

Doctor Pomeroy points out in his report that the public health affairs of thirty-nine cities in the county are efficiently taken care of under the present plan, which is applicable to any city within the county boundaries.—*Los Angeles Times*, October 16.

* * *

Cut Number of Less Fit

Editor of *The Bee*—Sir: During the peak of the depression it was found that among those families of low social status, low income and unemployment, there was more sickness and malnutrition among the children and a higher birth rate among the parents than in other families. A report of the National Resources Committee (May 14, 1938) states that where living standards were the lowest the birth rate was 70 per cent more than enough to replace the parents; where living conditions were the highest there was a deficit of 17 per cent in the reproduction rate.

An analysis of the above shows that if one hundred parents of the lowest standard group were given sufficient humanitarian aid to avoid disease and other misfortunes, and if their descendants were to propagate at the same rate, thirteen generations would produce 167,000 descendants; while if one hundred parents of the highest standard group continued their reproductive rate for the same period, there would be living but nine descendants. Long before that time we would be overwhelmed by degeneracy and chaos.

History teaches that the great nations of the past began to decline in their greatness when they reached that period of economic sufficiency that work was not an essential for many, and the least fit were placed on a dole and allowed to produce an unlimited number of offspring who became consumers and not producers.

Our nation is drifting close to the breakers. An eugenics program to reduce the number of the less fit and increase the number of the most fit is the solution to the problem.—Eugene H. Pitts, M. D., Sacramento, October 5, 1940.—*Sacramento Bee*, October 7.

* * *

San Francisco Poll Approves Medical Examination Before Marriage

By DAN E. CLARK II
Director, Front Door Ballot Box

California's required medical examination before marriage rated almost unanimous approval among San Fran-

ciscans when their sentiment on this subject was checked by the latest Front Door Ballot Box survey.

At the same time, the survey indicates, approximately two-thirds of all San Franciscans believe this requirement causes many couples to go outside the State for their marriage licenses.

Cross Section

In the course of this survey, conducted expressly for *The Examiner*, trained interviewers were sent to persons in a scientifically calculated cross section of the city's total adult population. The following question was asked:

"Do you approve or disapprove of the present required medical examination for a marriage license?"

Here is the way those having opinions answered:

Approve 94%
Disapprove 6%

(Only one person in thirty-three had no definite opinion when asked this question.)

The general point of view was that a restriction of this sort is effective in promoting social welfare and more generally satisfactory marriages.

Healthier People

"It makes for a healthier race," said a drug store clerk.

Objections to the medical examination law appeared to be mainly on grounds it is a restriction of freedom. The wife of a city employee contended it "wasn't needed for the last hundred years; why should we have it now?"

The proprietor of a magazine shop declared, "You can't legislate people into being moral."

It is interesting to note that, although nearly every one favored the law, a significant majority readily agreed many couples avoided it by being married outside California. The question on that point was answered:

Yes 66%
No 34%

(Approximately one person in six had no opinion in the matter. These are not included in the above tabulation.)—San Francisco Examiner, October 17.

• • •

British Doctors Urge Armor to Prevent Shrapnel Wounds Germans Reported Using It as Protection for Their Soldiers in Modern Warfare

Chicago, Sept. 5 (AP).—The well-dressed British soldier will wear streamlined armor if England's doctors have their way.

The belief that a modification of medieval armor has a place in modern warfare was expressed at a recent meeting of the Royal Academy of Medicine Surgeons reported in the *Journal* of the American Medical Association.

They noted that the Germans were reported to be using body armor.

Suggestions included larger helmets, visors, gantlets, curtains of chain mail attached to the back of helmets and steel or compressed fiber plates for chest protectors.

The old objection to armor—that it would overload the soldier—was regarded as no longer applying, because of the extensive mechanization of army movements and the development of lighter protective materials.

Specimens of compressed fiber, including bakelite, were said to have "the same tensile power as aluminum but half its weight" and to be adequate protection against shrapnel.

Doctors noted that in the last war many soldiers were killed by small missiles entering the chest and ripping up one of the great vessels or the heart.—Los Angeles Times, September 6, 1940.

* * *

Health Department Made Federal

Urged to Put Secretary of Health in Cabinet

Chautauqua, N. Y., Sept. 5 (UP).—Inclusion of a secretary of health in the Cabinet is urged by Dr. Nathan Van Etten of New York, President of the American Medical Association.

Addressing a group of physicians at Chautauqua Institute, Doctor Van Etten slashed at what he called "amateur philosophers and log-rolling politicians whose superficial humanitarianism has been stimulated by job-seeking welfare agencies."

Reviewing advances in American medical technique during the past century, Doctor Van Etten recalled that Bismarck and Lloyd George both had set up compulsory health insurance as a means of gaining the support of their peoples. He admitted that the time was "more than ripe" for a national health program, but urged that it be established with the utmost care by skilled professional men.

"I would like to see a new national department to be known as the Department of Health headed by a secretary who must have had a medical education and be licensed to practice medicine," he declared.

Referring to national budgeting for health, Doctor Van Etten attacked the "stratosphere extravagances" of the Wagner Health Act and similar "excursions into Utopia."

"I believe that needs for health should be discovered in the smallest political subdivision such as the school district, then referred to the township, to the county, to the state, to the Federal authority in that order and that the Federal authority should be called upon as infrequently as possible," he said.

The medical leader also urged local physicians to realize their responsibilities in seeing to it that an eventual health program be professionally-sound rather than merely politically-expedient.—San Francisco News, September 5, 1940.

LETTERS

Concerning Reprint of Articles on Socialized Medicine Reprinted from "Rocky Mountain Medical Journal" in October Issue of "California and Western Medicine."

EDITOR'S NOTE: In the September issue of CALIFORNIA AND WESTERN MEDICINE, on page 133, appeared a page reprint of an article taken from the *Rocky Mountain Medical Journal*, giving the views of the Republican Presidential nominee, Wendell Willkie, Esq., on the subject of "Socialized Medicine."

In the October issue, on page 181, a similar page was reproduced from the *Rocky Mountain Medical Journal*, in which Mr. Stephen Early, secretary to the President, presented a statement of President Franklin D. Roosevelt's views on the subject. On page 182 was given an additional letter sent to the OFFICIAL JOURNAL by Elmer Belt, M. D. Below appears a letter dated October 14, subsequently received from Secretary Stephen Early. President Roosevelt's address referred to, in substance, was as printed on page 182 of CALIFORNIA AND WESTERN MEDICINE. Secretary Early's later letter of October 14, follows:

(COPY)

THE WHITE HOUSE
WASHINGTON

October 14, 1940.

George H. Kress, M. D.
Editor, California and Western Medicine
2004 Four Fifty Sutter
San Francisco, California

Dear Doctor Kress:

Please accept the President's thanks for your letter of September 2, forwarding a tear sheet of page 133 from the September issue of CALIFORNIA AND WESTERN MEDICINE.

The President's views on the subject therein dealt with were expressed in a speech delivered at the Jersey City Medical Center, Jersey City, New Jersey, on October 2, 1936, and for your information I have much pleasure in enclosing a copy of that speech.

The views expressed by the President on that occasion have in no wise been changed or modified since the delivery of the speech in question and still constitute a complete statement of his principles.

Very sincerely yours,

(Signed) STEPHEN EARLY,
Secretary to the President.

Concerning Report of a Committee of the San Francisco County Medical Society: Re "Drivers' Qualifications."

(COPY)

CHARLES A. NOBLE, JR., M. D.
SAN FRANCISCO

October 7, 1940.

Dear Doctor Kress:

I enclose the report of a Committee of the San Francisco County Medical Society, appointed last January to make a

report on "Drivers' Qualifications." It is the feeling of our committee that some of the facts here outlined should be brought to the attention of as wide a group of physicians as possible.

If this report were published, I am sure no one would read it because of its length. Would it be possible to have an abstract—I suggest the one I am enclosing—published in the JOURNAL so that its contents might be called to the attention of more of your readers?

Very truly yours,

CHARLES A. NOBLE, JR., M. D.

Abstract of Report of San Francisco County Medical Committee Appointed to Aid California Safety Council Committee on Drivers' Licenses

1. Increased motor transportation brings increased hazards.
 2. Number of accidents attributable to illness not known at present.
 3. Even if most accidents attributable to other factors, medical profession has responsibility to attempt reduce that proportion of accidents due to illness.
 4. State Motor Vehicle Code now has wide powers to refuse licenses.
 5. Powers ineffective unless illness reported by physicians.
 6. New State law adds epilepsy to list of reportable diseases.
 7. By interpretation physician *must* report to local health office any patient subject to recurrent spells of unconsciousness whether spells witnessed or not.
 8. State Board of Health notifies Department of Motor Vehicles which then has power to refuse or cancel driver's license.
 9. In practice Motor Vehicle Department makes independent investigation with patient's family and if no confirmation, calls on attending physician for details.
 10. Undoubtedly other diseases exist which make drivers a menace—especially chronic vertigo, circulatory disturbance, mental deficiency, alcoholism, drug addiction, insanity.
- Committee at present recommends:
- (a) Education of physicians to realize that certain patients are a menace while driving automobiles.
 - (b) Urging of physicians to discuss problem with patients concerned.
 - (c) Encouragement of physicians to report not as "epilepsy" but as "recurrent unconsciousness" all patients so affected, irrespective of cause.
 - (d) Encouragement of all possible coöperation by physicians with Board of Health and with Motor Vehicle Department in educational program and in gathering statistics which will help in future evaluation of magnitude and importance of problem.

Concerning National Institute of Health: Research in Problems of Aging.

(COPY)

FEDERAL SECURITY AGENCY
UNITED STATES PUBLIC HEALTH SERVICE
NATIONAL INSTITUTE OF HEALTH
WASHINGTON, D. C.

October 17, 1940.

Dear Doctor Kress:

The National Institute of Health is beginning the development and organization of a research unit to be concerned entirely with the problems of aging. The importance and future significance of this field of research are obvious when one considers the rapid shift in the average age of the population of the country. The problems concerned with the aging process have ceased to be of mere academic interest and have become urgently imperative.

Prior to the actual inauguration of a clinical and research program, we are attempting to survey what work is being done along these lines by American scientists. Personal letters of inquiry are going out to as many of these investigators as we have reason to believe have a special interest in this field, but we are anxious to reach everyone even potentially interested. Because publication in scientific journals may reach many who would otherwise be omitted,

I am herewith submitting the enclosed informational résumé in the hope that you may give the matter brief editorial notice or incorporate the statement in the section devoted to news and comment in CALIFORNIA AND WESTERN MEDICINE.

Your coöperation in facilitating the search for information will be greatly appreciated. For your personal information may I say that thus far the replies received from many scattered investigators have indicated an extraordinary interest, enthusiasm, and whole-hearted desire to coöperate.

Sincerely yours,

EDWARD J. STIEGLITZ, M. D.
In Charge, Investigations in Gerontology.

Concerning an Applicant for Narcotic Medication.

(COPY)

EDWARD BLAIR, M. D.
HEALDSBURG, CALIFORNIA

October 9, 1940.

To the Editor:—I enclose copy of letter I have just sent to Narcotic Enforcement Division. To make it intelligent I must add that this Arthur G. Kuhn was referred to me Sunday evening, September 29, by one of the local pharmacies; and he succeeded in getting some morphin and atropin from me, and in passing a worthless check. Thursday, October 3, I learned, on conversation with Dr. T. E. Albers, Secretary of Sonoma County Medical Society, and other Santa Rosa doctors that he had attempted to work the same game on them early on Sunday and practically all day Monday, September 30.

That convinced me that he is an addict rather than a bona fide sufferer of asthma, and I reported promptly to the Division of Narcotic Enforcement on their regular report cards and in a covering letter.

I think it would be appropriate for you to broadcast a warning in CALIFORNIA AND WESTERN MEDICINE so that other doctors in the state may be on the lookout for him, and not only save themselves inconvenience and embarrassment, but aid in his arrest by reporting to their local peace or police officers that there is a warrant out for this man's arrest in Sonoma County on a bad check charge. . . .

Thanking you, I remain

Yours truly,
EDWARD BLAIR, M. D.

(COPY)

EDWARD BLAIR, M. D.
HEALDSBURG, CALIFORNIA

October 9, 1940.

Division of Narcotic Enforcement
156 State Building
San Francisco, California
Gentlemen:

I refer to my letter of October 3, 1940, re Arthur Kuhn. As stated in that letter, I accepted a check on the Seattle First National Bank for \$2.50. This check was returned marked "Cannot locate account," and I have turned it over to the Justice of the Peace, Healdsburg Township, to support a warrant for Mr. Kuhn's arrest.

He should be easy to pick up due to his habit of attempting to work the asthma story on physicians. I am reporting the case to CALIFORNIA STATE MEDICAL JOURNAL in the hopes that they will warn other doctors in the state.

To make my description a bit more detailed, Mr. Kuhn, who apparently has several aliases, is about 45 years old, 5 feet 7 inches tall, slight build, narrow face, dark, as if from sun rather than racial pigmentation, blue or gray eyes; wore rather dark nondescript clothing, claimed to be a World War Veteran, and gives a story of suffering

from asthma, which is unrelieved by epinephrin and the other sympathicomimetic drugs. He says that he has been relieved by morphine and atropine, and states that addicts never want it with atropine.

Having been taken in by this party's story, I have been hit in my professional pride as well as my purse, and will do all I can to coöperate with the authorities on his apprehension.

Yours truly,

EDWARD BLAIR, M. D.

✓ ✓ ✓

(COPY)

EDWARD BLAIR, M. D.
110 MATHESON STREET
HEALDSBURG, CALIFORNIA

October 23, 1940.

Editor, California and Western Medicine,
450 Sutter Street
San Francisco, California

Dear Sir:

I refer to my letter of October 9 re Arthur G. Kuhn.

I was informed yesterday by Mr. F. Leslie Manker, Assistant District Attorney of Sonoma County, that Mr. Kuhn was recently arrested in Contra Costa County for passing bad checks; and that he was sentenced about a week ago to six months in the county jail at Martinez.

I think it will be well to give this additional fact publicity so that the doctors in the State can be on the lookout for Mr. Kuhn in case he attempts to exercise his habits after completing his sentence.

Yours truly,

EDWARD BLAIR, M. D.

Concerning Articles in "California and Western Medicine," reprinted from "Rocky Mountain Medical Journal."

(COPY)

DRS. AYRES AND ANDERSON
LOS ANGELES

October 3, 1940.

To the Editor:—I want to thank you for your letter containing proof sheet of the advanced proof of reprint of an article from the *Rocky Mountain Medical Journal*. The spirit of fair play which has been exemplified in this matter should be deeply appreciated by all the members of the Association.

Very sincerely,

DRS. AYRES AND ANDERSON.
By Samuel Ayres, Jr., M. D.

Concerning Donation by California Medical Association to Lane Medical Library.

(COPY)

THE BOARD OF TRUSTEES
OF THE
LELAND STANFORD JUNIOR UNIVERSITY
San Francisco, California,
September 27, 1940.

Dr. George H. Kress, Secretary-Treasurer
California Medical Association
450 Sutter Street
San Francisco, California

Dear Doctor Kress:

At a recent meeting of the Board of Trustees the President of the University reported receipt of your Association's check for \$1,595, as an annual contribution to the Lane Medical Library.

This continued support is very gratifying. The individual members of the Board have asked me to express their warm appreciation of your interest and liberality.

Very truly yours,

IRA S. ILLICK, *Secretary*.

Concerning Medical Journals: Years Ago and at Present.

Monrovia, September 17, 1940.

To the Editor:—Thanks for your letter of September 13, containing the excerpt from the "Twenty-Five Years Ago" column of CALIFORNIA AND WESTERN MEDICINE.

It is interesting to note the change that has taken place in journalism since that address was given. Today *The Journal of the American Medical Association* and the state journals have taken on a much more scientific aspect, and we now have numerous journals to supply the deficiency that I mentioned. I had been a subscriber for numerous European journals and could not help but note the difference in their attitude toward scientific medicine and ours. This was in the period when we had a dearth of journals for the good articles, and I might also say that we had a dearth of good articles for the journals that existed. It was difficult for a student to get what he wanted out of the two or three journals for which the average man subscribed. . . .

Sincerely yours,

FRANK M. POTTINGER.

Concerning Legal Requirement for Presence of an Assistant During Operations.

(COPY)

San Francisco, October 14, 1940.

Pat Malloy, Jr., Esq.
Attorney at Law
704 World Building
Tulsa, Oklahoma

Dear Sir:

Your letter of October 7, 1940, addressed to Doctor Dukes, has been forwarded to me as General Counsel of the California Medical Association.

In your letter, I note that you inquire as to whether or not a surgeon is required by law in California to have an assistant during the performance of an appendectomy. So far as I know, there is no statute or decision in California directly or indirectly requiring the presence of an assistant during the performance of a surgical operation of any kind. Of course, under a number of California cases the operating surgeon is responsible for any negligence occurring during the course of the operation, whether such negligence be on his part or on the part of assistants, nurses or anesthetists, and, under these decisions, it might be argued that failure to have an assistant is in and of itself negligence in the event that any injury occurs which might have been avoided if there had been an assistant. This, however, is merely an argument that could be made.

I know of no statutory decision which requires the presence of an assistant.

Very truly yours,

HARTLEY F. PEART.

Concerning Possible Violation of California Medical Practice Act, by Nurse-Dietitian.

San Francisco, October 4, 1940.

State Board of Medical Examiners
C. B. Pinkham, M. D., Secretary
515 Van Ness Avenue
San Francisco, California

Dear Doctor Pinkham:

Enclosed herewith find copy of a letter dated September 30, sent to me by a physician friend.

I have underlined the query that has been put up to me.

I am passing this case on to you for consideration, with request that you give me your opinion.

Cordially yours,

GEORGE H. KRESS, M. D.,
Secretary.

(COPY)

September 30, 1940.

To the Editor:—I am writing concerning the problem of a dietitian who has become interested in food allergy. She, herself, had a chronic symptomatology which was cleared by the elimination of a number of foods to which marked allergy occurred. She then began to work on some of her own family and gradually on friends, and during the last year or so, various other people in her community have been coming to her through her solicitations. Some of these patients have been sent by her to their physicians, but many of the patients have come to her independently and, as I understand it, have presented their problems to her for therapeutic advice. She has decided on her own part, without medical confirmation, that many of these individuals are suffering from food sensitization, and she has manipulated their diets, oftentimes with very definite benefit to the patients.

I have told her that I feel that she is practicing medicine and taking unwarranted responsibility in the diagnosis and advice which she has been giving these individuals. *I want to know if she is justified by law in doing this type of work which I have described, and whether she would be liable to prosecution or fine.*

On her part she feels that she has had considerable training in dietetic work, having specialized in this field when she was in the University, and she feels it is justifiable for her to give patients counsel in regard to the diets which are indicated. This is done, however, as I have already stated, without any medical supervision. Your opinion concerning this dietitian's activities would be greatly appreciated.

With kindest regards, I am

Most sincerely yours,

✓ ✓ ✓

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF
PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS

San Francisco, Calif.
October 8, 1940
Yours of October 4
Re: Dietetics.

California Medical Association
George H. Kress, M.D., Secretary
450 Sutter Street
San Francisco, California

Dear Doctor Kress:

From the facts set forth in the unsigned copy of the letter which accompanied yours of October 4, we judge that the individual is violating the Business and Professions Code, relating to the practice of medicine, in that she is prescribing for ailments of the human system, regardless of whether it is a diet or a medicinal preparation.

We would appreciate your sending us the name of the individual referred to.

Very truly yours,

C. B. PINKHAM, M.D.,
Secretary-Treasurer.

Concerning Five-Year Cures of Cancer.

(COPY)

AMERICAN COLLEGE OF SURGEONS

To the Editor:—In 1922 the American College of Surgeons appointed a Committee on the Treatment of Ma-

lignant Diseases by Surgery, Radium, and X-Rays (now known as the Cancer Committee). This committee collected and analyzed records of cases of cancer of the cervix and breast, and published the results. In 1932 the College extended this phase of the work and since then has accumulated records of thirty thousand five-year cures of cancer of various organs. In the meantime the importance of accurate and complete records has been impressed upon the cancer clinics which have been established and upon the medical profession generally. . . .

It is now desired to add to the College cancer archives records of as many as possible five-year cures of cancer, and contributions to its cancer archives are again being solicited from surgeons and radiologists who treat cancer cases, whether in cancer clinics or not. Abstract cancer record forms have been evolved by the College and their use is widespread. The use of these forms ensures the recording of information that is essential for the purposes of clinical research, including an appraisal of methods of treatment. To be of sufficient value for clinical research the records should be furnished on the forms recommended by the College, or their equivalent, and the College will provide such forms on request. The results of such analyses and studies of their cases as have been made by individuals, hospitals, and clinics will be a particularly valuable and welcome addition to the College archives. . . .

Large hospitals and clinics which treat many cases of cancer are requested to designate the appropriate individuals on their staffs who are especially qualified to present records of cancer of different organs, as in such institutions the work may be exclusively departmentalized. In order that an analysis of the records may be made and an announcement of an impressive addition to our thirty thousand cures may be presented at the Clinical Congress of the College to be held in Chicago, October 21 to 25, 1940, it is requested that the records be submitted for this year not later than September 15, 1940. From year to year this activity will be continued and annual contributions will be solicited.

40 East Erie Street, Chicago.

Very truly yours,

(Signed): BOWMAN C. CROWELL,
Associate Director.

Concerning Acquisitions in Lane Medical Library.

(COPY)

THE STANFORD UNIVERSITY LIBRARIES
STANFORD UNIVERSITY
CALIFORNIA

October 19, 1940.

Dr. George H. Kress
Secretary, California Medical Association
Four Fifty Sutter
San Francisco, California

Dear Doctor Kress:

Thank you for your good letter of October 15.

In accordance with your suggestion, future issues of our list of selected acquisitions at the Lane Medical Library will be sent to the various county medical societies and to the larger hospitals.

We plan to print four hundred copies of the next issue. This list seems to be meeting a real need.

Cordially yours,

NATHAN VAN PATTEN,
Director.

Concerning Request for Reprints for Army Medical Library.

(COPY)

WAR DEPARTMENT
ARMY MEDICAL LIBRARY
WASHINGTON, D. C.

October 22, 1940.

Sir:—I am directed by the Surgeon-General to inform you that authors' reprints are gratefully received at the Army Medical Library. They are placed in a special collection catalogued by author and thus form a ready bibliography of the work of any given writer and a valuable supplementary source of material when the volume of original publication is temporarily unavailable at the bindery or on loan.

Editorial notice of this collection would be much appreciated.

Very respectfully,

HAROLD W. JONES,

Colonel, Medical Corps, United States Army,
Librarian

Concerning Vacancies in Governmental Medical Agencies.

(COPY)

UNITED STATES CIVIL SERVICE COMMISSION
WASHINGTON, D. C.

*Applications Closed for Temporary and Part-Time
Civilian Medical Officers for Army—Doctors
Needed for Other Medical Positions*

The Civil Service Commission announces that enough applications have been received to meet the prospective need for temporary and part-time civilian medical officers in connection with the Army expansion.

The Commission calls attention to the fact, however, that there is an urgent need for medical officers and senior and associate medical officers to fill permanent positions in other agencies. Applications will be received until further notice. The positions pay from \$3,200 to \$4,600 a year. Fourteen specialized branches of medicine are included.

There is also an urgent need to fill junior medical officer positions at \$2,000 a year at St. Elizabeth's Hospital, Washington, D. C.

Full information and application forms for these examinations may be obtained at the office of the Secretary, Board of United States Civil Service Examiners at any first- or second-class post office, or from the United States Civil Service Commission, Washington, D. C., or from any of the Commission's district offices.

October 8, 1940.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

To What Extent May a Physician or Surgeon Make Assurances to His Patient?

The fact that good psychology often encourages and may necessitate statements by the physician that "everything will be all right," "no harm will result from this," etc., often places the physician in an embarrassing position

in reference to legal liability should the treatment not turn out successfully.

Although it seems unfair and unwise for the law to interfere with the physician's judgment in making such assurances, there is a California case which holds that a physician may be held liable for breach of warranty where such assurances have been made to the patient. Under the theory of the case, if assurances are unfulfilled, liability exists even though due care and reasonable skill was used. The case under discussion is *Crawford vs. Duncan*, 61 Cal. App. 647. There a woman, fond of social contacts, consulted a physician with reference to swollen glands on the right side of her neck. The physician stated that surgery could relieve the condition, but that a scar would result. The physician, in view of the patient's desire to keep her neck free from disfigurement, suggested that she have the glands treated by radium and sent her to the defendant, a radiologist.

The defendant, according to the evidence, told plaintiff that radium treatments had been very successful in treating small swellings in glands of that description without leaving a scar of any kind and assured plaintiff that there would be no permanent scar in her case. The defendant explained that radium was generally used so that there would be no scars and, in fact, was used to eliminate scars, birthmarks, etc.

Throughout the treatment defendant frequently assured the plaintiff that any disfigurement which might result from his use of the radium would disappear with the lapse of time. At the end of the treatment there was a running sore on plaintiff's neck, but defendant told her that if she would give it time the neck would become normal.

Approximately three years after the treatment, plaintiff brought suit for breach of warranty, stating that where the running sore had healed a permanent scar remained, contrary to the defendant's assurances. It was held that the plaintiff had a right to proceed to trial on the breach of warranty theory without regard to the presence or lack of negligence, and that the Statute of Limitation would run against the plaintiff only from that time when a reasonable person could know with a reasonable degree of certainty that a permanent scar had developed as a result of the treatments.

The possible extensions of the rule of this case are alarming. May a physician whose patient has a nervous temperament resort to assurances of no harm and successful result, in order to convince the patient that he should permit performance of an act necessary from the standpoint of good medical practice? If he does, the patient might bring suit years afterward if a condition later arises which could be attributed to the treatment. In such a situation, recovery could be had for the breach of warranty, even though the treatment was in conformity with the rules of good medical practice, was carefully and skillfully done, and was for the patient's best interests.

It is the opinion of the author that the rule of the Crawford case is not only harsh and inconsistent with the general principles which render a physician vulnerable only in case he is guilty of malpractice, but also very detrimental to the policy of allowing a physician to use some discretion as to how to accomplish an act which is clearly for the patient's benefit. However, until some statute is enacted requiring all suits against physicians or surgeons resulting from injuries from treatment to be based on malpractice or requiring warranties by a physician to be in writing, there is danger that the Crawford decision may, on the basis of *stare decisis* (established precedent), stand as the law of California.

Until the law of California is changed either by statute or by a decision overruling the Crawford case, physicians should be exceedingly careful of the assurances which they make to patients.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, presenting copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 11, November, 1915

From Some Editorial Notes:

On Criticism.—Some thoughts on criticism in general have been suggested by the fact that a number of people in Sacramento have more or less heatedly taken the editor to task for an editorial note which appeared in the JOURNAL, criticizing the policy of a city in turning out a full-time health officer, and presumably a well-trained one, as he was, we understand, picked in competitive examination. The point is that the editor was attacked for publishing certain criticism; there was no discussion of the thing criticized! If one is to be personally attacked for uttering words of criticism, it would seem logical to show first that the thing criticized is essentially right and that hence the critical words were improperly used. If a criticism is just, it is no argument against it to berate the critic. If it can be shown that it is not just, then the critic should most certainly be taken to task for his improper and unwarranted use of critical words. It may be conceded that no one likes to be criticized and that when anything is criticized, someone is sure to be offended thereby, either rightly or wrongly. If no one and nothing were ever criticized; if errors and mistakes and misdemeanors were never pointed out, what a chaotic world we would live in, and how impossible life would become! . . . Time alone will show the right or the wrong of this particular thing. To attack the editor does not alter the right or the wrong of the thing mentioned. It is often discouraging to have personalities injected into a discussion of things or conditions as such. And it certainly is much easier to go through life openly admitting that all things are possible and that everybody is right!

✓ ✓ ✓

Rockefeller Foundation and Hookworm.—The Rockefeller Foundation has recently issued an annual report, largely dealing with its International Health Commission, and purposes hereafter to issue such reports each year. The work of this one branch of the Foundation is stupendous. . . .

✓ ✓ ✓

Test Your Wassermann!—There is a story about a man, upon whom a certain rude community had imposed the duty of dispensing justice; he declared his intention of hearing only one side of the case; "for," said he, "to hear two sides would have a tendency to confuse the court."

Such an evasion of the problem resulting from a conflict of testimony is not always feasible in the practice of medicine; and we can not help wondering how widespread is the trouble of mind which the practitioner suffers from the contradictory reports issued by workers who make the Wassermann tests. To stick to a single serologist would secure the mental repose which the backwoods justice was so anxious to preserve; but we fear that a regular assumption of one's Wassermann worker's infallibility would not be compatible with one's duty. . . .

One lesson to be learned from this, if the lesson needed learning, is that the physician must not abdicate too readily in favor of the laboratory worker, but must keep his clinical head. Furthermore, a laboratory method convenient for the use of the practitioner himself, to serve as a check upon the serologist, is very much desiderated. . . .

(Continued in Front Advertising Section, Page 22)

† This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.
Secretary-Treasurer

News

Report by Special Agent Hunter relates that an individual using the name Reverend George Baker was arrested by him at Livermore after he had prescribed a dilute solution of listerine for Hunter, who posed as a patient; that Baker has been identified as an individual named Cohn, who, according to the Federal Bureau of Investigation, has quite a criminal record and has operated all over the western part of the country, being active in California for only three months. A clipping from the Sacramento Bee of October 1, 1940, related in part as follows:

"Harry Cohn, 59, who, the investigators said, went by the name of Rev. George Baker when conducting his business of fortune telling and spiritualism, was in the Butte County jail on a charge of petit theft, filed by his former partner, Ange From, 50, the miner, who declared Cohn defrauded him of \$76. Constable Tom Reeves returned Cohn from Watsonville, where he had been arrested by the local police. Reeves said his investigation disclosed that Cohn had an electrical device which is supposed to reveal the presence of gold. He said From told him he paid \$76 for a reading and Cohn went into a trance and on coming out promised to find treasure buried in the Santa Cruz mountains. From declared: 'All I got was exercise.' A second charge of petit theft was filed against Cohn yesterday by John A. Taylor of Willows. Taylor said he put up \$132 to finance a treasure hunt."

—————

"St. Louis Estes, raw food advocate, today was sentenced to 150 days in the county jail and fined \$2,500 by Municipal Judge White. Estes, convicted last week of ten counts of practicing medicine without a license, was denied a new trial. Through his attorney, J. A. Brown, he filed notice of appeal. Judge White fixed bail at \$500 pending outcome of the appeal. It was the second trial for Estes. His first conviction was set aside because of a jury mixup. Estes, formerly a Southern Californian, brought his theories of food and health here about two years ago. With him came his large family—all adepts at practicing his theories. Dr. Estes is 75. Estes was accused by Arthur A. Derrickson, 55, of 955 Ellis Street, who contended he had paid Estes \$1,130 for treatment of impaired sight." (San Francisco News, September 27, 1940.) (Prior entries, May, 1930; November, 1935; March, 1936; December, 1938; February and November, 1939; May, 1940.)

—————

"Dr. Hermann Frederick Erben, naturalized Austrian-born physician, was denied passage as an ordinary seaman on the American President liner *President Garfield* which sailed for the Orient yesterday. Erben, who has been under surveillance of the FBI for alleged 'fifth column' activities, was removed from the ship's rolls by company officials shortly before sailing time at noon. The widely traveled medical specialist had previously signed on and had worked two days as an ordinary seaman while the transpacific liner was in port. In accordance with U. S. regulations governing the employment of seamen, Erben is entitled to one month's pay in addition to wages for the time. Captain L. H. Westdahl, marine superintendent here for the American President Lines, confirmed the incident, saying Erben

(Continued in Front Advertising Section, Page 30)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

FLEXIBLY—CONVENIENTLY—ECONOMICALLY *Packaged*

ANOTHER RESPONSIBILITY OF LEADERSHIP



WHEN Baxter began to supply Parenteral Solutions in VACOLITERS, only the Liter size was provided. Soon it became apparent that a Half Liter—a Double Liter—would sometimes prove convenient and economical.

To supply a wide range of solutions in new sizes meant additional filling machinery, records, inventories of cartons, labels, and price lists; and greatly increased stock inventories at all warehousing points. From the beginning, however, Baxter has recognized its responsibility to provide whatever the best interests of the profession may indicate.

However broad the requirements, hospitals may specify Baxter Parenteral Dextrose and Saline Solutions with assurance not only of wide variety and highest quality, but also of packaging in containers of all needed sizes—containers which in every case are complete VACOLITERS (approved by the American College of Surgeons) with their exclusive visible index of vacuum.

IN developing its now widely accepted new technique for aseptic indirect Blood Transfusion, Baxter has been guided by these same considerations of convenience and economy in use.

With the Baxter TRANSFUSO-VAC. Drawing the Blood, Citrating, Transporting, Storing, Filtering and Infusing are all accomplished in and from a single vacuum container, bridging both time and space without break in asepsis. Procedure is almost automatic in its convenience, enabling one operator to perform the entire sequence with remarkable economy of time and effort, and without wasting a drop of blood. Citrate* contents are supplied in three quantities—for 250, 500 and 750 cc. of Blood. Accessory sets are provided for every important requirement.

For the average hospital, the safe rule is to stock two more TRANSFUSO-DONOR SETS than the maximum number of blood transfusions per day.

*2½ Sodium Citrate in Physiological Solution of Sodium Chloride in the Baxter TRANSFUSO-VAC

One of a Series on the Progress of Intravenous Infusion and Blood Transfusion.

DON BAXTER, INC.

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THE POTTENGER SANATORIUM AND CLINIC

For Diseases of the Chest

Monrovia, California

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

CHOICE rooms and bungalows at rates ranging from \$35 per week up, including medical service, general nursing, x-rays, routine laboratory examinations, ordinary medicines and therapeutic pneumothorax.

A few accommodations as low as \$25 per week assigned on special application in selected cases.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

For particulars address:

THE POTTENGER SANATORIUM AND CLINIC, Monrovia, California

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LOCAL DISTRIBUTORS WANTED

KING AMBULANCE COMPANY

Transporting the Sick since 1906

West 1400

**2570 Bush Street
SAN FRANCISCO**

**Physicians' and Surgeons'
Telephone Exchange
Nurses' Bureau**

BOARD OF MEDICAL EXAMINERS

(Continued from Front Advertising Section, Page 30)

the State Board of Medical Examiners to reinstate the Banning doctor's license. Judge F. A. Leonard of San Bernardino County, presiding here on assignment, heard the trial. The physician was represented by Attorney Frederick Wing of Banning in the legal processes which extended over more than a year. . . . *Riverside News*, September 3, 1940.)

"Charged by the State Medical Board with violation of his probation, Dr. W. G. Cardew, 72, chiropractor, was booked at the county jail yesterday. A bench warrant for

the chiropractor's arrest was obtained in Judge Grandin H. Miller's court by Thomas Hunter, inspector for the medical board. Doctor Cardew had been fined \$100 and placed on two years' probation last April. A condition of his probation was nonpractice of medicine." (*San Jose Mercury-Herald Weekly Shopper*, September 6, 1940.) Under date of October 8, 1940, Special Agent Hunter reported that William G. Cardew admitted the violation of his probation to Judge Miller of the San Jose Justice Court on October 7 and the matter was put off calendar, with the understanding that Cardew would immediately close his office and would leave San Jose for a period of at least three months. "Cardew promised to sell his office equip-

(Continued on Page 37)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

The Effectiveness of AMNIOTIN



IN RELIEVING MENOPAUSAL
SYMPTOMS IS AN
ESTABLISHED FACT

ELEVEN years ago Sevringhaus and Evans¹ reported that Amniotin was "of marked value in the relief of the vasomotor phenomena of the menopause." This observation has been confirmed by so many published clinical papers that the effectiveness of Amniotin in relieving distressing menopausal symptoms is widely recognized.

For example, Novak² in a paper on the management of the menopause states: "The fact remains, however, that a certain proportion of women suffer with severe vasomotor symptoms for a variable and unpredictable time, and that the lot of these women can be made much easier by intelligent organotherapy. Whereas formerly there was much difference of opinion among clinicians as to the efficacy of hormone treatment, opinion is now unanimous that it is of genuine value. In fact, organotherapy for menopausal symptoms is looked upon as one of the more satisfactory applications of

endocrine knowledge in the field of gynecological practice."

Early, Adequate Treatment Suggested

Schneider³ citing experience in 519 cases writes: "... the ease with which complete relief can be obtained in the early cases, has been one of the most striking observations. . . ." The milder forms of disturbance often can be controlled by the oral administration of Amniotin in capsules. Larger doses may be administered advantageously by the hypodermic route.

Amniotin is a highly purified preparation of naturally occurring estrogenic substances. It is available in Capsules containing 1000, 2000 and 4000 I. U., Pessaries of 1000 and 2000 I. U., and in 1-cc. ampuls containing 2000, 5000, 10,000 and 20,000 I. U.

¹ Sevringhaus, E. L., and Evans, J. S.: *Am. J. M. Sc.* 178:638, Nov. 1929.

² Novak, Emil: *Surg. Gynec. & Obst.* 70:124, Jan. 1940.

³ Schneider, P. F.: *Am. J. Obst. & Gyn.* 37:861, May 1939.

For literature address the Professional Service Department
E. R. Squibb & Sons, 745 Fifth Avenue, New York, N. Y.

Amniotin

A SQUIBB PREPARATION OF ESTROGENIC SUBSTANCES
OBTAINED FROM THE URINE OF PREGNANT MARES

When
Mothers' Milk
 is not
 available...



USE LACTOGEN



It is universally recognized that the milk from the cow is a very satisfactory and successful substitute for mothers' milk if offered in proper form and proportion. That is why Lactogen is made wholly from fresh cows' milk.

Taken from tuberculin-tested herds, the milk used in making Lactogen is completely checked for cleanliness and freshness before acceptance . . . then processed in shining, spotless, stainless steel drying chambers under ideal modern conditions of control and sanitation.

Lactogen is fresh, whole cows' milk, fortified with additional milk fat and milk sugar to match human milk proportions of fat, protein, and carbohydrates.

Lactogen is an easily digestible food. The characteristics of the casein are changed to form fine and flaky curds, and the fat globules are physically broken down.

Lactogen is especially convenient and safe. It may be used even where there is no refrigeration. Its preparation is simple, even for the most inexperienced mother.

NO ADVERTISING OR FEEDING DIRECTIONS, EXCEPT TO PHYSICIANS

For free samples and literature, send your professional blank to "Lactogen Department."

NESTLÉ'S MILK PRODUCTS, INC.
 155 EAST 44TH ST., NEW YORK, N. Y.

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St. Luke's Hospital

SAN FRANCISCO

A Limited General Hospital of 200 Beds



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Fully approved by the American College of Surgeons and the American Medical Association for Resident and Intern Training.

Limited Facilities for Part-Pay Treatment

BOARD OF MEDICAL EXAMINERS

(Continued from Page 34)

ment and never to reopen his office. If he continues with his practice, it will be merely by making house visits."

"Comely, dark-eyed Beth Wilkinson, 34, self-styled 'Reincarnated Priestess of Biblical Chaldea,' has been fined \$100 and sentenced to ten days in the county jail for violating the California medical practice act. Municipal Judge Theresa Meikle also sentenced Jacob Nowak, 84, an accomplice, to a six months' suspended sentence. Special Agent Joseph Williams of the State Board of Medical Examiners testified the pair referred to themselves as physicians in treating Mrs. Joy Thayer of the Better Business Bureau at their healing headquarters, 9 Scott Street. Miss Wilkinson's personal card bore the inscription: 'Beth, Reincarnated Priestess of Biblical Chaldea, Spiritual Healer Divine—by appointment.' She was released on \$250 bail after giving notice she would appeal the court's conviction." (San Francisco Chronicle, September 25, 1940.)

"Federal Judge Frank Norcross denied a writ of habeas corpus for Prince Alexis Romanoff, who asserted he was held in the county jail in Reno as an alien under orders of the United States District Attorney's office. Romanoff was taken into custody in Reno July 2 by immigration authorities on a warrant issued in Washington." (Associated Press Dispatch dated Carson City, Nevada, September 19, printed Sacramento Bee, September 19, 1940.) (Previous entries, May, 1934; August, 1939.) (This individual was featured in the 1937 Annual Report of the Board of Medical Examiners under the name of Trotsky.

(Continued on Next Page)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature



C·I·B·A

Now Presents

SULFATHIAZOLE

for Pneumococcal and Staphylococcal Infections

SULFATHIAZOLE (the thiazole analogue of sulfapyridine), carefully administered, has shown a definite chemotherapeutic effect in the treatment of pneumococcal and staphylococcal infections.

Its chief advantages, compared to sulfapyridine, seem to be more uniform absorption, less conjugation after absorption, less tendency to cause serious nausea or provoke vomiting, and greater effectiveness against the Staphylococcus. Sulfathiazole already has been used in over 2,000 pneumonia patients with good results.

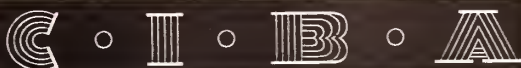
SULFATHIAZOLE, "Ciba" (2-Sulfanilyl-Aminothiazole) is available in 0.5 gram tablets, in bottles of 50, 100, 500 and 1000. Also available are 5 gram bottles of Sulfathiazole crystals for making solutions to be used as a reagent in estimating the sulfathiazole content of the blood.



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BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

"Dr. Lee A. Stone, Madera city and county health officer, has been elected president of the California Health Officers Association. . . ." (*Madera Tribune and Mercury*, September 19, 1940.)

"Unlicensed medical practice was charged yesterday against an Oakland chemist, arrested on a local warrant in connection with the death of a San Jose girl he had allegedly treated for tuberculosis. The subject, Robert Thompson Fowler, about 60, had posed as a 'tuberculosis specialist,' according to State Medical Examiner J. W. Williams. His arrest was the outgrowth of a case in which 18-year-old Josephine Sportello of 759 North Twelfth Street, died here August 1. Williams, who filed charges against Fowler in Judge Grandin H. Miller's court, said the arrested man had been treating patients with some sort of inhalant, claiming a cure of ninety-six out of a hundred cases. The Sportello girl had been ill for months. She was a daughter of Mr. and Mrs. Frank Sportello. The father is a local fish market owner." (*San Jose Mercury-Herald*, September 14, 1940.) (Previous entries, May, June, August, 1926; April and May, 1929.) Commenting thereon, the *San Jose News* of September 16, 1940, printed an editorial reading as follows: "An Oakland chemist has been arrested and charged with practicing medicine without a license. A special agent for the State medical board claims the man treated a local girl for tuberculosis and that she subsequently died. This case should be prosecuted with particular vigor to determine if this man was one of that large group who prey upon the sick and ailing. There are few more despicable activities than claiming to treat diseases which the pseudo physician is not qualified to treat. Tuberculosis is not the scourge it

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once was and, if detected early and competently treated, is not difficult to control. It needs the most competent care, however, administered by an intelligent, well-trained physician. Such care a quack is not qualified to give."

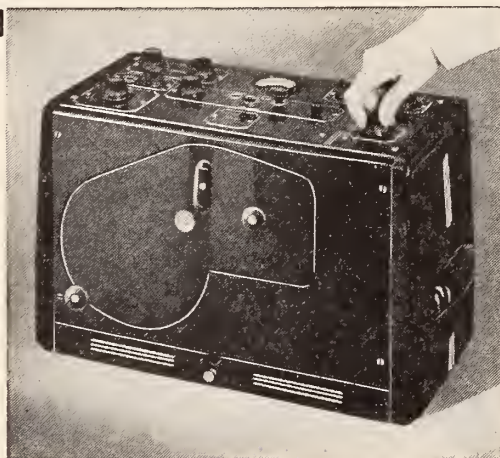
"A jury in the courtroom of Superior Judge Edmund P. Mogan yesterday assessed the value of services rendered by a Los Angeles physician during the last illness of Joseph B. Strauss, late Golden Gate Bridge engineer, at \$600. A verdict for that amount was returned against Strauss' widow. The physician, Dr. Edwin H. Schneider, sued for \$7,500, asserting that he attended Strauss from March, 1938, until his death from a heart ailment and other complications in June of the following year." (*San Francisco Chronicle*, September 21, 1940.)

"Pleading guilty to practicing medicine without a license, Floyd E. Risdon, 39, operator of the Golden Gate College of Massage, was sentenced to pay a \$250 fine or spend sixty days in jail by Municipal Judge Frank Dunn today. . . ." (*San Francisco Call-Bulletin*, October 5, 1940.) Special Agent Hunter's report on Floyd E. Risdon relates: "A copy of a Los Angeles Report indicates that on March 19, 1940, Risdon was found guilty in Huntington Park Justice Court of violation of Section 2141 of the Business and Professions Code and was fined \$100, which fine was suspended. . . ." Among the material taken on search warrant, Special Agent Hunter reported approximately fifty blank diplomas on the Huntington Park College and approximately twenty-five letterheads reading "Golden Gate College," together with approximately fifty business, as well as fifty treatment, cards bearing the name "Golden Gate College."

(Continued on Page 40)

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Vitamin B ₆	100 gamma
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BOARD OF MEDICAL EXAMINERS

(Continued from Page 38)

"Dr. Grover C. Talbot, prominent San Jose chiropractor, who suffered a nervous breakdown following his arrest here in 1937 on an abortion charge and was committed to Agnew State Hospital as insane, was restored to capacity by an order of Superior Judge Charles Davison today. Testimony in court was that since his confinement, Doctor Talbot has recovered his sanity and is able to manage his affairs. No prosecution will follow, however, since records of Justice Chester W. Moore's court revealed that the charge—supplying a Palo Alto girl with medicine to cause an abortion—was dismissed on motion of the district attorney's office September 13, 1938." (San Jose News, September 27, 1940.) (Previous entries, August and October, 1936; October, November and December, 1937.)

United States Public Health Service.—To the broad sweep of our outlying citizenry, "U. S." still connotes "Uncle Sam," a benevolent whitebeard, an oracle who knows all the answers for those beset and perplexed by personal problems.

He "lives" in Washington, D. C.; it is, therefore, perfectly natural for "the people" to forward their questions to someone whose address includes those magic initials, "U. S." No agency of the Federal Government in Washington, no bureau, division, office, department, administration, commission, section, or service, but receives its daily grist of queries by mail.

The United States Public Health Service has never been slighted by lack of inquiring letters.

Each post brings its batch from all corners of this country and abroad, from metropolis, flag-stop, and farm home.

(Continued on Page 42)

As an Adjunct in the Treatment of Alcoholism

'Benzedrine Sulfate' is admittedly not a solution of the difficult problem of alcoholism, but *is* a valuable adjunct in cases which can be properly supervised.

Acute Alcoholism

Amplifying and confirming a previous report, Reifenstein and Davidoff (N. Y. State J. Med., 40:247, 1940) used 'Benzedrine Sulfate' orally and intravenously* in a carefully-controlled series of more than 100 institutionalized alcoholics, with and without psychosis. In almost all cases, states of alcoholic depression were quickly relieved.

"In the acute alcoholic psychoses the length of time necessary for recovery was considerably diminished, frequently by half, and the number of recoveries was slightly increased."

"In the acute phases of alcoholic intoxication amphetamine sulfate has been most effective. Likewise the characteristic physiologic and psychologic after-effects of acute inebriation have been dissipated quickly by the drug."

Chronic Alcoholism

Working with institutionalized patients, Reifenstein and Davidoff did not find 'Benzedrine Sulfate' therapy satisfactory in chronic alcoholism.

In private practice, on the other hand, Bloomberg had good results in a series of twenty-one closely supervised chronic alcoholics. (New Eng. J. Med., 220:129, 1939). He suggested that the use of 'Benzedrine Sulfate' may permit a sufficient interval of sobriety for the institution of the usual and more fundamental psychotherapeutic approaches.

Initial dosage should be small, 1/4 to 1/2 tablet (2.5 mg. to 5 mg.). If there is no effect, this should be increased progressively. Normal dosage is from 1 to 3 tablets (10 mg. to 30 mg.) daily, one-half of the dose at breakfast and the other half at noon.

*Physicians wishing to use 'Benzedrine Sulfate Ampules' may obtain them on direct order from us.



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Each tablet contains 10 mg. amphetamine sulfate, S. K. F. (approximately 1/6 gr.)

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(Continued from Page 40)

By far the largest proportion of these letters, according to a study of 9,795 recent ones, by Dr. Robert Olesen, Assistant Surgeon-General ("What People Ask About Health," *Public Health Reports*, May 12, 1939), concern medical and public health subjects—facilities for care, personal hygiene, nutrition, infant care, sanitation, use of drugs, healing cults, health laws, statistics, and "cure-alls." The bulk of them are received by the Division of Sanitary Reports and Statistics, and answered by specialists within the Service. Some are unanswerable; the majority could have been better answered nearer home.

"The medical and public health questions asked by the people of this country," explained Doctor Olesen, "undoubtedly vary greatly from year to year. Therefore, the queries recorded in the present study can be regarded as

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typical only in a general way. Epidemics of diseases such as poliomyelitis and influenza, public discussion of medical care problems, announcements of new methods of treatment, illnesses of prominent persons, and the like, immediately precipitate a flood of inquiries, comment, and suggestions relative to such matters of current interest. At the same time, pursuit of knowledge concerning questions of general health continues quite evenly and unabated."

Here is a fair sample at random of the types of information requested: Susceptibility of a person to rabbit fever; dirt eating; how to get rid of germphobia; recent discoveries in the medical world; spectacles for the blind; how to preserve life; garlic—twenty questions on its medical use; bacteria on coins; cure for cigarette habit; most healthful regions of the United States; use of bone and dried chicken gizzard for treatment of cataract; effects of eating tung nuts; health value of barracuda; eating poison ivy leaves as a preventive; method of eliminating scars; embalming fluids; what is thyphen; therapeutic uses of radio; etc.

In preparing replies for its numerous correspondents, the Public Health Service utilizes not only its own resources, but those of a score of other Federal and of voluntary agencies. Besides approximately 2,000 reprints from the *Public Health Reports*, the Public Health Service also has some 400 multilithed statements, single copies of which are sent in response to specific requests for information. When a trend of questioning is noted for which material is not at hand, a special statement is prepared by someone familiar with the subject. Upon several occasions, outstanding medical specialists outside the Service have cooperated in preparing authentic articles. When neither printed nor duplicated material is available, appropriate

(Continued on Page 44)



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(Continued from Page 42)

answers are prepared by persons in the Service best fitted to supply the required information.

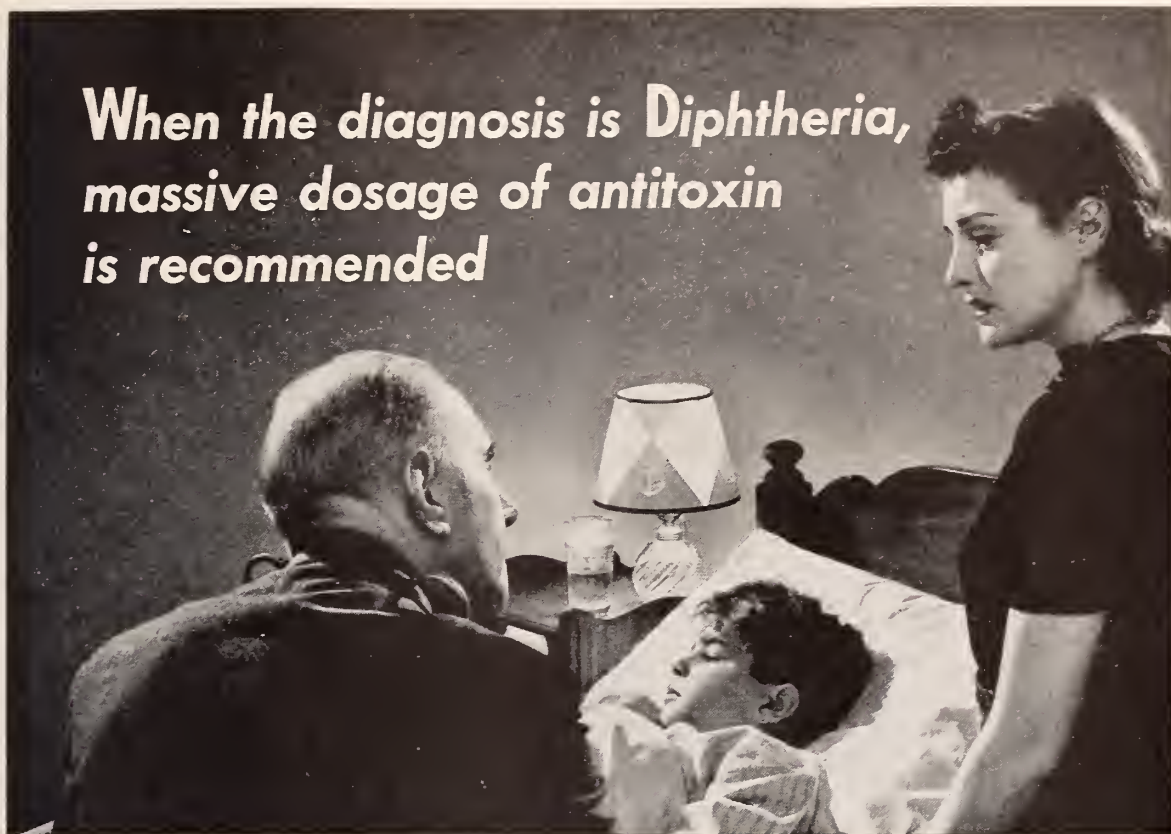
"The vast majority of letters presenting 'cure-alls,' and they are surprisingly frequent," said Doctor Olesen, "have common characteristics. They almost always come from the ignorant, whose knowledge of spelling and composition is rudimentary; and more often than not, the letter is written with pencil on a poor grade of scratch paper. Many of these correspondents are elderly men and women with too much unoccupied time on their hands. Retired persons, housewives, and individuals whose work leaves extended intervals for reflection are among those who devote their spare time to pondering on the ills of mankind and devising means of relieving them.

"Many times the proposed 'infallible' remedy is not original but was gleaned from an old medical book, or was passed down in the family by an illustrious ancestor, or was obtained from an old Indian chief. Another factor common to such 'discoveries' is their supposed applicability to a number, even a host, of ailments. Whereas the wise physician cautiously applies a single remedy of known action, the correspondent extolling a 'cure' finds his material useful for many illnesses. Moreover, the cure is quick in action, low in cost, immediate in its relief, and permanent in its results. Not even paralysis and permanent disability are obstacles to the person with a 'cure.'

"There is still another distinctive characteristic of the person with a claim, theory, or remedy, namely, his acknowledged willingness to receive or his demand for a reward for his 'shotgun' concoction. Seldom does he exhibit the altruistic magnanimity of offering his discovery for the general welfare of mankind, to be used without remuneration to himself. Though there is no evidence,

(Continued on Page 46)

When the diagnosis is Diphtheria, massive dosage of antitoxin is recommended



WHEN diphtheria antitoxin was first introduced, physicians hesitatingly administered 300 to 1,000 units of this new therapeutic agent, yet this small dosage startlingly reduced the high mortality rate. Since then, overwhelming evidence has demonstrated beyond question that massive dosage is indicated in the treatment of diphtheria.

Mulford Diphtheria Antitoxin, Purified Globulin, is well adapted for the administration of large unit dosage. Because of the reduction in bulk, it is easy to administer and causes less pain to the patient. It is rapidly absorbed and develops quicker patient response due to more rapid neutralization of the toxin. Although highly concentrated, it is isotonic with the blood. It is low in protein.

Mulford Diphtheria Antitoxin, Purified Globulin, is supplied in syringes of 1,000 units; 5,000 units; 10,000 units; 20,000 units and 40,000 units. Our complete line of diphtheria biologicals also includes *Mulford Diphtheria Toxoid, Alum Precipitated, Refined* in $\frac{1}{2}$ -cc. and 1-cc. doses; *Mulford Diphtheria Toxoid (Anatoxine Ramon)*; *Mulford Diphtheria Toxin for the Schick Test*; and *Mulford Diphtheria Toxin for Schick Test Control*.

Chart,¹ showing general tendency toward reduction in mortality rate as initial dose of diphtheria antitoxin is increased:

Hospital	Average Primary Dose	Mortality Percentage
A	9,000	7.81
B	13,700	3.84
C	15,000	5.43
D	16,000	4.40
E	17,000	2.87
F	22,000	2.66

¹ Brit. M. J., 2:1132, Dec. 19, '31

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(Continued from Page 44)

scientific or otherwise, in support of his contentions, he specifies a cash sum, frequently ranging between \$100,000 and \$1,000,000, as an appropriate reward for his devotion to his fellow man. Foreign correspondents, unable to gain a hearing for their preposterous claims in their own countries, are particularly prone to specify large sums for divulging their secrets to supposedly unenlightened Americans.

"To persons presenting claims in behalf of theories, discoveries and cures, the Public Health Service has a uniformly courteous but firm reply. In the first place, the Public Health Service has neither the inclination nor the facilities for investigating such claims, very few of which are offered by qualified persons or appear to possess merit. Second, the burden of proof for evidence that a remedy is effective rests upon the person who suggests it. Evidence would consist of results by unimpeachable scientific investi-

gations and endorsement by reputable medical societies, laboratories, and other organizations. In the absence of such evidence there is little reason for serious consideration of the steady flow of claims for various remedies.

"There is a serious side to the 'sure cures' devised by the ignorant and unscrupulous, and this concerns the administration of worthless or harmful drugs to the sick in the absence of a diagnosis of the ailment. Not only are the sick often deprived of skilled treatment, but a damaging delay in such treatment occurs while a worthless remedy is being administered. It is known, from frequent admissions that have been made by the inventors of remedies, that there is widespread violation of the medical practice laws.

"In a few instances the exploiters of remedies of secret composition have urged their claims in person, often traveling considerable distances to reach Washington. The personal presentation of their claims has accomplished little beyond the personal satisfaction afforded and has uniformly discouraged the further promotion of the particular remedy or method advocated."

A considerable experience with persons seeking information about general health and medical care, according to the study, leads to the conclusion that very few of them utilize data from the most accessible sources. In general, information of both these types may be obtained most conveniently through the medium of the local school—or public library, health officer, or other authority in one's own community. In the event that queries are not readily answered by local officials, recourse may be had to the State Department of Health, usually very well equipped for supplying reliable information.

"When these sources fail to provide needed data," the study continued, "questions may be addressed to Federal agencies, including the Public Health Service, in Wash-

(Continued on Page 48)

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(Continued from Page 46)

ington. It should be a matter of interest to every citizen of the country, however, to know just what part the Service plays in protecting the health of our people.

"Numerous letters received indicate, for one thing, that too many persons have an erroneous conception of its work, thinking that it treats and prescribes for individuals. It does not do this: such treatment is left to the family physician, or to local health officers maintained by town, county, or state clinics. Nor does the Service prescribe sanitary regulations for the states: that duty remains under the jurisdiction of the states themselves.

"The Service is equipped to provide four different kinds of information. First, information about its own activity: how it is organized; the scope of its personnel; and the different aspects of its work. Second, data which comes into it through the reporting services of a veritable peace-time division of 'dollar-a-year' assistant collaborating epidemiologists, whose coöperation is necessary in order that proper measures may be taken to prevent the further spread of disease, and in order that the efficacy of the preventive and control measures taken may be judged. Third, data about disease which becomes available through reports of the studies of the cause and means of propagation and spread of diseases of mankind, and the development of

methods of prevention and control. Fourth, information for the individual about the things he can do to maintain his health or to assist his community in its public health program.

"Most of this latter kind of information goes out through the local health departments themselves, and many of the publications of the Service are distributed by the local health department to their own people. Such information is, however, given directly when people write in and ask for it.

"Not all answers in these fields can be given, however. There are many diseases about which we know very little. New research may change our best present knowledge of other diseases as scientific discovery progresses. Only those things which sound medical authority accepts as true can be stated with assurance.

"Neither can all questions as to the prevalence of all diseases be answered. All diseases need not be reported to health departments. Many diseases, such as syphilis, for example, which the law requires be reported, are not reported regularly. Some states and many foreign countries have not developed their health departments sufficiently to provide that information. The Public Health Service seeks to encourage better reporting; but its answers to such ques-

(Continued on Page 50)

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(Continued from Page 48)

tions must depend upon the completeness of the reports it gets."

There are figures of prevalence given in the weekly Public Health Reports on the principal communicable diseases. However, there are many diseases concerning which there is no accurate information as to incidence. These "nonreportables" include, for example, such widely dissimilar conditions as hay fever, cirrhosis of the liver, tonsillitis, rheumatism, heart disease, appendicitis, nephritis, and hernia.

The Public Health Service maintains several research laboratories, most important of which is the National Institute of Health in Washington, D. C. Generally speaking, it is the duty of the Institute to engage in research designed to protect the public health. The studies so undertaken may be fundamental in nature, or they may have immediate and direct application. They may be confined to a highly specialized branch of medicine; they may touch upon problems of sanitation; or they may involve related studies. They are limited only by the funds and personnel available, always bearing in mind that they must pertain to the public health.

"Requests for diagnosis of a disease and for medical treatment in specific cases cannot be answered by mail," Doctor Olsen advised. "These are both matters which require personal examination and oftentimes repeated observations of a patient. Symptoms do not make a diagnosis. Drugs and diet are prescribed by wise physicians for a given patient—and not for a disease. The dose, the frequency, and the administration of drugs, as well as advice about hygiene, must be determined for each individual. The Public Health Service, therefore, limited by law in its responsibilities, and by sheer physical lack of facilities, replies only to such questions as can be answered intelligently without seeing the patient."

A last point here may concern the matter of birth and death records: the Public Health Service does not have them. For vital statistics, write to your state, county, or local custodian, giving the name, the date, and the place of birth or death. This custodian may be the county clerk, clerk of the county court, city or town clerk, the state registrar, or secretary of the State Board of Health. Form 2473, issued by the United States Civil Service Commission, will supply all the information one may require about establishing the date of his birth.

Foot Troubles.—It is estimated that 90 per cent of all people in the United States suffer from some kind of foot trouble, according to findings of the United States Public Health Service.

The studies indicate that a great extent of America's foot trouble could be avoided if individuals will follow a few simple and effective preventive measures.

The figures for the general population have their counterpart in groups likely to be called for military service. Figures for the last war showed 80 per cent of the men were rejected for military service because of defects of the feet. It is expected that figures for the present group will equal or exceed those for the last war.

The recommendations of the Public Health Service are as follows:

1. Select shoes and hose that fit properly. Tight shoes cause pressure and shoes that are too large cause friction. The heels of shoes should be kept straight.
2. Shoes should be well supported through the arch of the foot, particularly for children whose feet tend to flatten when they stand up.

(Continued on Page 52)

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(Continued from Page 50)

3. The growing child should be taught the importance of foot cleanliness, and how to protect the feet against ill effects of what may seem to him to be minor injuries.

4. During adult life foot trouble may be a part of a general bodily condition where attention should be directed toward the improvement of the general health.

5. When standing for long periods, place the feet 2 to 4 inches apart, point them straight ahead and support the weight on the outside of the feet.

6. In stepping forward the weight should fall first on the heel, whereupon the body is carried forward over the foot, weight being applied along the outside of the foot from the heel to the small toe and finally across the forward part of the great toe.

7. The toenails should be cut straight across and not too short.

8. Frequent cleansing and careful drying of the feet, together with frequent changes to dry hose and shoes, may aid in relieving excessive perspiration.

9. Prompt care of all wounds and blisters on the feet may prevent serious consequences.

10. Fallen arches are the result of weakened leg muscles which allow the main or lengthwise arch in the foot to sag. An orthopedic surgeon should be consulted about this condition, as special treatment frequently is indicated.

11. The feet should be bathed at least once a day with soap and warm water and then thoroughly dried.

12. Exercise the feet. The arches may be strengthened by bending the toes—best accomplished by picking up small objects, such as marbles, with the toes.

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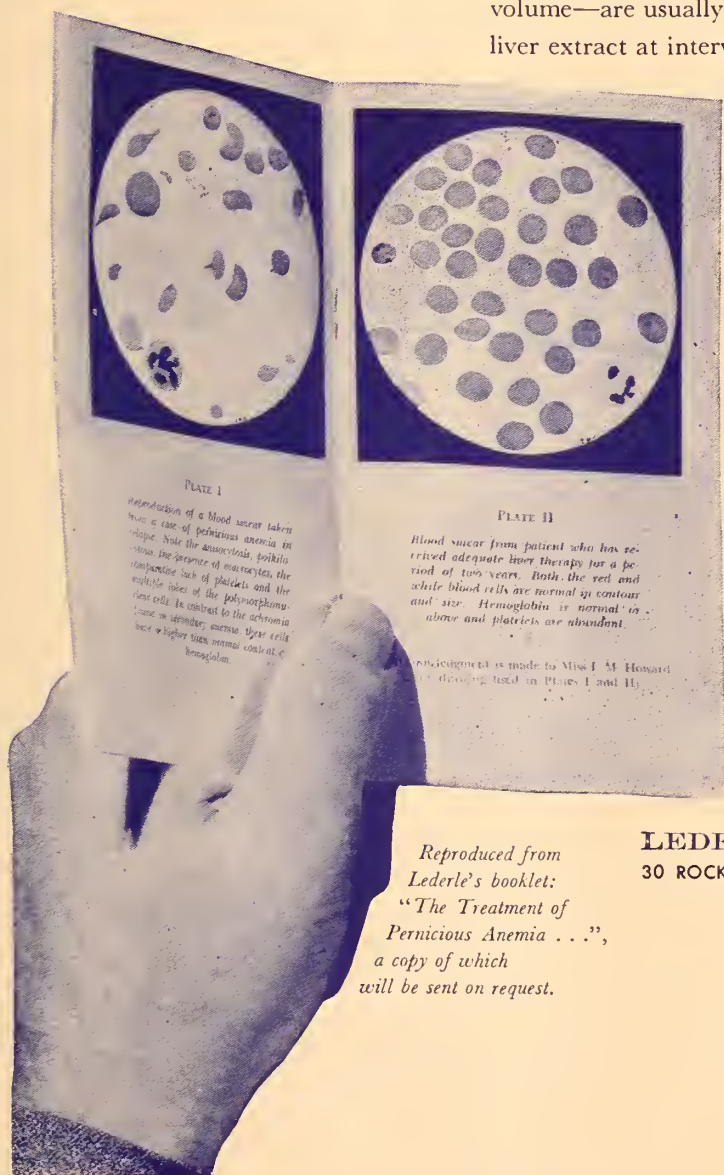
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Secretary, J. E. Young, 405 Rowell Building, Fresno.
Meeting, *First Tuesday, University-Sequoia Club, Fresno.*

Humboldt County Medical Society
President, John N. Chain, Fourth and E Streets, Eureka.
Secretary, Joseph S. Woolford, 350 E Street, Eureka.
Meeting, *First Thursday.*

Imperial County Medical Society
President, William A. Clarke, 132 Fifth Street, Holtville.
Secretary, Claude F. Peters, 722 Main Street, El Centro.
Meeting, *Third Tuesday, 7:00 p. m., Barbara Worth Hotel, El Centro.*

Inyo-Mono County Medical Society
President, Lloyd S. Bambauer, 705 Home Street, Bishop.
Secretary, Clarence L. Scott, 609 Elm Street, Bishop.
Meeting, *Fourth Wednesday, Methodist Church, Bishop, except December, January, February.*

Kern County Medical Society
President, C. S. Compton, 428 C Street, Bakersfield.
Secretary, Eric F. Colby, Hopkins Building, Bakersfield.
Meeting, *Third Thursday, 8:00 p. m.*

Kings County Medical Society
President, P. K. Edmunds, Corcoran.
Secretary, William A. Johnstone, Hanford.
Meeting, *Second Monday, 8:00 p. m., Legion Hall, Hanford.*

Lassen-Plumas-Modoc County Medical Society
President, W. B. McKnight, Portola.
Secretary, Bernard S. Holm, Quincy.
Meeting, *On Call.*

Los Angeles County Medical Association
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President, Roy E. Thomas, 1136 W. Sixth Street, Los Angeles.
Secretary, L. A. Alesen, 1925 Wilshire Boulevard, Los Angeles.
Meeting, *First and Third Thursdays, 1925 Wilshire Boulevard, Los Angeles.*

Marin County Medical Society
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Secretary, Carl W. Clark, 1010 B Street, San Rafael.
Meeting, *Fourth Thursday, Deer Park Villa, Fairfax.*

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President, Dallas L. Wagner, 615 Main Street, Fort Bragg.
Secretary, Royal Scudder, Fort Bragg.
Meeting, *On Call.*

Merced County Medical Society
President, William E. Fountain, 557 Seventeenth Street, Merced.
Secretary, James A. Parker, Bank of America Building, Merced.
Meeting, *Third Thursday, Hotel Tioga, Merced.*

Monterey County Medical Society
President, Mast Wolison, 215 Franklin Street, Monterey.
Secretary, Arnold Manor, 215 Franklin Street, Monterey.
Meeting, *First Thursday.*

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President, Frank X. McGreane, Silverado Sanatorium, Calistoga.
Secretary, M. M. Booth, Bruck Building, St. Helena.
Meeting, *First Wednesday.*

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Secretary, Glenn Curtis, 323 North Pomona Street, Brea.
Meeting, *First Tuesday, 8:00 p. m., Chapel of the Orange County Hospital, Orange.*

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Meeting, *At Call of President.*

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President, Thomas A. Card, 3616 Main Street, Riverside.
Secretary, W. Philip Corr, 3616 Main Street, Riverside.
Meeting, *Second Monday, 8:00 p. m., Library, Riverside Community Hospital.*

Sacramento Society for Medical Improvement
President, Norris R. Jones, M. D., 1127 Eleventh Street, Sacramento.
Secretary, Glenn E. Millar, 321 Physicians Building, Sacramento.
Meeting, *Third Tuesday, 8:30 p. m., Auditorium, Sacramento.*

San Benito County Medical Society
President, J. M. O'Donnell, Hollister.
Secretary, L. E. Smith, Hollister.
Meeting, *At Call of President.*

San Bernardino County Medical Society
President, Eugene H. Hull, San Bernardino.
Secretary, A. E. Varden, Medico-Dental Building, San Bernardino.
Meeting, *First Tuesday, 8:00 p. m., San Bernardino County Charity Hospital.*

San Diego County Medical Society
1410 Medico-Dental Building, 233 A Street, San Diego
President, Joseph Weinberger, Medico-Dental Building, 233 A Street, San Diego.
Secretary, C. V. Bernardini, 1410 Medico-Dental Building, 233 A Street, San Diego.
Meeting, *Second Tuesday, University Club.*

San Francisco County Medical Society
2180 Washington Street, San Francisco
President, William Reilly, 490 Post Street, San Francisco.
Secretary, L. Henry Garland, 2180 Washington Street, San Francisco.
Meeting, *Every Tuesday, 8:15 p. m., 2180 Washington Street, San Francisco.*

San Joaquin County Medical Society
President, Hugh J. Bolinger, Farmers and Merchants Bank Building, Lodi.
Secretary, George H. Rohrbacher, 1005 Medico-Dental Building, Stockton.
Meeting, *First Thursday, 8:15 p. m., Medico-Dental Club Rooms, Stockton.*

San Luis Obispo County Medical Society
President, F. W. Yocom, 732 Thirteenth Street, Paso Robles.
Secretary, E. M. Bingham, County Health Department, San Luis Obispo.
Meeting, *Third Saturday, 6:30 p. m., Gold Dragon Cafe, San Luis Obispo.*

San Mateo County Medical Society
President, Carl D. Benninghoven, Mills Memorial Hospital, San Mateo.
Secretary, Robert F. Monteith, 18 California Street, Redwood City.
Meeting, *Fourth Wednesday, Benjamin Franklin Hotel, San Mateo.*

Santa Barbara County Medical Society
President, Henry J. Profant, 1421 State Street, Santa Barbara.
Secretary, D. H. McNamara, 317 W. Pueblo Street, Santa Barbara.
Meeting, *Second Monday, Cottage Hospital.*

Santa Clara County Medical Society
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Secretary, Leslie B. Magoon, 652 East Santa Clara Street, San Jose.
Meeting, *Third Wednesday, 8:00 p. m., Medico-Dental Building, San Jose.*

Santa Cruz County Medical Society
President, A. F. Giberson, Watsonville.
Secretary, Samuel B. Randall, 84 Walnut Avenue, Santa Cruz.
Meeting, *First Tuesday of each month (except June, July and August), 7:30 p. m., Club Rio del Mar, Aptos.*

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Secretary, Bertram L. Treistad, 1536 Market Street, Redding.
Meeting, *Second Monday.*

Siskiyou County Medical Society
President, Charles Pius, Yreka.
Secretary, Victor W. Hart, 113 No. Oregon Street, Yreka.
Meeting, *Sunday on call.*

Solano County Medical Society
President, H. Randall Madeley, 727 Sonoma Street, Vallejo.
Secretary, John W. Green, Box 539, Vallejo.
Meeting, *Second Tuesday, 8:00 p. m., Casa de Vallejo Hotel, Vallejo.*

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Secretary, T. E. Albers, 600 B Street, Santa Rosa.
Meeting, *Second Thursday.*

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Meeting, *Second Friday, 7:30 p. m., Hotel Hughson.*

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President, H. H. Beck, Corning.
Secretary, F. J. Bailey, Red Bluff.
Meeting, *At Call of President.*

Tulare County Medical Society
President, Ray E. Cronemiller, 160 South E Street, Exeter.
Secretary, Forrest G. Powell, 222 W. Willow Street, Visalia.
Meeting, *Sunday Evening once a month.*

Ventura County Medical Society
President, Harry E. Barker, 1484 East Main Street, Ventura.
Secretary, A. A. Morrison, 625 Main Street, Santa Paula.
Meeting, *Second Tuesday, Ventura County Club.*

Yolo County Medical Society
President, Edwin K. Copeland, 405 First Street, Woodland.
Secretary, Wilfred T. Robbins, 719 Second Street, Davis.
Meeting, *First Tuesday.*

Yuba-Sutter-Colusa County Medical Society
President, Ben F. Miller, Yuba City.
Secretary, Leon M. Swift, I. O. O. F. Building, Marysville.
Meeting, *First Tuesday.*

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Physician Says Tobacco May Be a Source of Arsenic Poisoning.—Tobacco as a possible source of arsenic poisoning is suggested in *The Journal of the American Medical Association* by Dr. E. E. Barksdale, Danville, Virginia, who points out that lead arsenate has been used for years by farmers as an insecticide on the plant to kill the horn worm. He presents a series of cases of skin rashes, in none of which was it possible to determine any source

of arsenic other than tobacco. As result of his findings in a group of patients being treated for syphilis he believes that any person under syphilitic treatment who gets a skin inflammation after injections of arsphenamin should not use tobacco in any form.

Doctor Barksdale says that all of the tobacco on the American market contains arsenic in a form which may be taken up by the human body and that nothing is done during the agricultural or manufacturing process to remove it and that probably nothing can be done.

"Lead arsenate is essential to the tobacco industry," he says. "It should be considered as an industrial hazard. Farmers use it as an insecticide because it is the most efficient and inexpensive one available. Indeed, its efficiency is probably responsible for the fact that it remains on the tobacco when it reaches the consumer. It has the property of sticking to the tobacco. This is the reason why it is so effective. Remaining on it throughout, it kills the young worms as they are hatched. It is impossible to wash it off because in so doing the tobacco would be ruined. There is no chemical process known that will remove it."

In discussing eight cases of arsenical skin inflammation, Doctor Barksdale says: "All the patients were emphatically cautioned against the use of tobacco and they recovered and have remained so since. Three of them have had mild recurrences every time they used tobacco."

He says that it is believed that patients get this dermatitis (skin inflammation) because they have a low point of tolerance to arsenic. "Fortunately, the point of tolerance for arsenic of most persons is much higher than the amount of arsenic that one could consume from tobacco," he adds.

In conclusion, Doctor Barksdale carefully points out that: "This paper has attempted to present a theory. Its ultimate proof depends on the collaboration of other workers."

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Advises Careful Physical Examination in Any Type of Sinus Disease.—A careful general investigation of the patient's physical condition in all types of sinus disease is advised by J. Mackenzie Brown, M. D., Los Angeles, in *The Journal of the American Medical Association* in an article wherein he points out that the treatment of sinus disease cannot be prescribed in hard-and-fast rules. Individualism in treatment is as essential here as in any other branch of medicine.

The general investigation, he says, may disclose important underlying causative factors that may avert unnecessary local treatment or surgery. Adequate drainage in both acute and chronic sinus disease is the greatest essential of treatment.

Doctor Brown says that certain cases of chronic sinusitis are basically of an allergic nature with superimposed pus producing infection. Unnecessary surgery may be avoided by investigation of this angle. Factors of importance in the chronic condition include disorders of the glands of internal secretion, excessive use of tobacco and alcohol, and vitamin and other dietary deficiencies.

In acute inflammation of the sinuses the patient should be kept in bed in a room with a warm, even temperature day and night. The swollen membranes should be shrunk by means of drugs.

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In severe infections, sulfanilamide, sulfapyridine, or sulfathiazole may be indicated, depending on the type of organism involved, Doctor Brown points out.

In the subacute phase, when the patient has no fever and usually is free from pain, after thorough nasal shrinkage, he advises a gentle irrigation of the nose with a warm solution, adding that he has found "these to be important measures in ridding the patient of the infection. In this stage a warm climate is of great value. It is important, however, that these patients keep their rooms warm at night, since the temperature may frequently drop from a high level in the day to a low one at night."

The term "compound fracture" does not refer to a bone broken in more than one place, but to the fact that the point of the break communicates with the outside air through a hole in the skin, Dr. Robert H. Kennedy, New York, points out in *Hygeia, The Health Magazine*.

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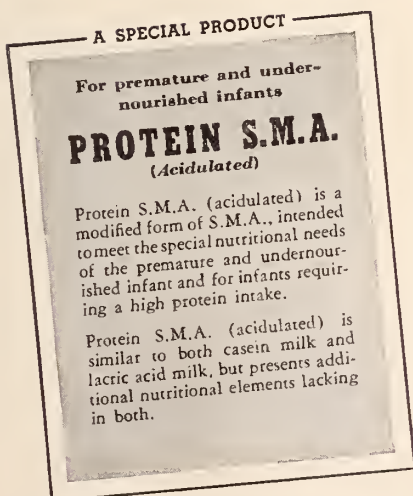
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Bacillary and Rickettsial Infections, Acute and Chronic, a Textbook. Black Death to White Plague. By William H. Holmes, Professor of Medicine, Northwestern University Medical School, Chairman, Department of Medicine, Passavant Memorial Hospital, Chicago. Cloth. Price, \$6. Pp. 676. New York: The Macmillan Company, 1940.

Otosclerosis. By Louis K. Guggenheim, M.D., F.A.C.S., Assistant Professor of Clinical Otolaryngology, Washington University School of Medicine. Fellow of the American Otolological Society, the American Laryngological, Rhinological and Otolological Society, the American Academy of Ophthalmology and Otolaryngology, and the American College of Surgeons. Cloth. Pp. 212. St. Louis: Louis K. Guggenheim, 1940.

The Neuroses in War. By Several Authors, Under the Editorship of Emanuel Miller, M. A. (Cantab), M. R. C. P., D. P. M. (Cambs), with a Concluding Chapter by H. Crichton-Miller, M. D., F. R. C. P. Cloth. Price, \$2.50. Pp. 250. New York: The Macmillan Company, 1940.

The Control of Tuberculosis in the United States. By Philip P. Jacobs, Ph.D., Director of Personnel Training and Publications, National Tuberculosis Association; Author of the Campaign Against Tuberculosis, the Tuberculosis Worker, etc. Revised edition. Cloth. Pp. 387. New York: National Tuberculosis Association, 1940.

A Treatise on Medicolegal Ophthalmology. By Albert C. Snell, M. D. Lecturer in Ophthalmology, School of Medicine and Dentistry, University of Rochester; Consultant in Ophthalmology, Strong Memorial Hospital, and Roches-

ter General Hospital; Ophthalmologist, Park Avenue Hospital, Rochester, New York; Member of the American Ophthalmological Society; Fellow of the American College of Surgeons, the American Medical Association, and the American Academy of Ophthalmology and Otolaryngology. Illustrated. Cloth. Price, \$6. Pp. 312. St. Louis: The C. V. Mosby Company, 1940.

Annual Report of the Board of Regents of the Smithsonian Institution. Showing the Operations, Expenditures, and Condition of the Institution for the Year Ending June 30, 1939. (Publication 3555) Cloth. Price, \$1.50. Pp. 567. Washington, D. C.: United States Government Printing Office.

Modern Marriage, A Handbook for Men. By Paul Popehoe, General Director, the American Institute of Family Relations, Los Angeles, California. Lecturer in Biology, University of Southern California. Second Edition. Cloth. Price, \$2.50. Pp. 299. New York: The Macmillan Company, 1940.

Synopsis of Materia Medica, Toxicology, and Pharmacology, for Students and Practitioners of Medicine. By Forrest Ramon Davison, B. A., M. Sc., Ph. D., M. B. Assistant Professor of Pharmacology in the School of Medicine, University of Arkansas, Little Rock. With forty-five illustrations, including four in color. Cloth. Pp. 693. St. Louis: The C. V. Mosby Company, 1940.

Diseases Affecting the Vulva. By Elizabeth Hunt, B.A., M. D., Ch. B. (Liverpool). Honorary Physician to the Skin Department, South London Hospital for Women; Honorary Dermatologist, New Sussex Hospital for Women and Children, Brighton; Temporary Honorary Dermatologist, Royal Infirmary, Liverpool; Formerly Senior Medical Officer, Radium Institute and Hospital for Skin and Cancer Diseases, Liverpool. With 36 illustrations and 18 plates in color. Cloth. Pp. 215. St. Louis: The C. V. Mosby Company, 1940.

Taber's Cyclopedic Medical Dictionary, Including a Digest of Medical Subjects. Medicine, Surgery, Nursing, Dietetics, Physical Therapy. By Clarence Wilbur Taber, Author,

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Taber's Dictionary for Nurses, the Cumulative Atlas of the Human Body, Taber's Dietetic Charts, Dictionary of Food and Nutrition, etc., and Associates. Two hundred seventy-three illustrations. Pp. 607. Cloth. Philadelphia: F. A. Davis Company, 1940.

Textbook of Ophthalmology. By Sir W. Stewart Duke-Elder, M. A., D. Sc. (St. And.), Ph. D. (London), M. D., Ch. B., F. R. C. S. Surgeon-Oculist to H. M. The King; Colonel A. M. S. Consulting Ophthalmic Surgeon to the British Army; Ophthalmic Surgeon, St. George's Hospital; Honorary Research Associate, University College, London; Lecturer in Ophthalmology, St. George's Hospital Medical School, University of London, etc. Vol. III. Diseases of the Inner Eye. With 1,140 illustrations, including 164 in color. Cloth. Price, \$18.50. Pp. 1,353. St. Louis: The C. V. Mosby Company, 1941.

The Treatment of Diabetes Mellitus. By Elliott P. Joslin, A. M., M. D., Sc. D. Medical Director, George F. Baker Clinic, New England Deaconess Hospital; Clinical Professor of Medicine Emeritus, Harvard Medical School; Consulting Physician, Boston City Hospital. Howard F. Root, M. D., Physician, New England Deaconess Hospital; Consultant in Medicine, Eastern Maine General Hospital; Massachusetts State Infirmary, Tewksbury, Middlesex County Tuberculosis Sanitarium; Instructor in Medicine, Harvard Medical School. Priscilla White, M. D., Physician, New England Deaconess Hospital; Instructor in Pediatrics, Tufts College Medical School. Alexander Marble, A. M., M. D., Physician, New England Deaconess Hospital; Instructor in Medicine, Harvard Medical School. Seventh edition, thoroughly revised. Illustrated. Cloth. Price, \$7.50. Pp. 783. Philadelphia: Lea & Febiger, 1940.

BOOK REVIEWS

Gynecologic Operations and Their Topographic-Anatomic Fundamentals. By Prof. Dr. Med. Heinrich Martius, Director of the University Women's Clinic, Göttingen. Authorized English Translation under the editorial supervision of W. A. Newman Dorland, A. M., M. D., F. A. C. S., Formerly Professor of Obstetrics, Loyola (Continued on Next Page)



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BOOK REVIEWS

(Continued from Preceding Page)

University School of Medicine, Diplomate of the American Board of Obstetrics and Gynecology, etc. Cloth. Pp. 486, with 404 mostly colored illustrations. Price, \$10. Chicago: S. B. Debaur, Publishers, 1939.

On first acquaintance with this rather unusual book, one becomes intensely interested. Few text books are so "readable" or so beautifully and well illustrated. In the title of the book, topographical anatomy is emphasized and throughout the entire text there are hundreds of illustrations, most of which are in color and all of which are clear and concise. Often semidiagrammatic drawings are made, eliminating the unnecessary anatomy and portraying the thought desired unusually well.

The various steps in surgery are well illustrated and it is not necessary to follow the text in many instances. The changes in topographical anatomy caused by disease, and

distortion at the time of surgery are excellently portrayed.

Lengthy discussions on differential diagnosis, indications for operative interference, types of instruments, and pre- and postoperative medication have been eliminated from this book. This is in contrast to many of the American texts and it is refreshing.

The author has limited his discussions to the most common procedures as done in the Göttingen Women's Clinic. He does not always go to the trouble of explaining all the operations that are used in a particular situation but presents briefly and clearly the procedure that he recommends.

Particular emphasis has been placed upon the treatment of urinary incontinence. Adequate space has been given to most of the common procedures of which the gynecological surgeon is called upon to treat. The occasional bowel operation that is encountered by the gynecological surgeon is also discussed.

Doctor Martius has clearly portrayed the techniques that he and his associates use. These are not always in accordance with common American methods but the techniques are interesting and worthy of serious consideration. The medical student and the hospital resident studying to become a gynecologist, as well as the established surgeon will find this book of real value, particularly as a reference book where brevity and proper illustrations are most desired.

Physical Diagnosis. By Ralph H. Major, M. D., Professor of Medicine in the University of Kansas. Second Edition, Revised. Cloth. Pp. 464, with 437 illustrations. Price, \$5. Philadelphia: W. B. Saunders Company, 1940.

The author has presented his subject in very readable form, drawing frequently on original descriptions and illustrations of conditions. This seems a natural consequence of his thorough familiarity with these descriptions from his previous researches and publications, and they fall very naturally into their place in this work. The book is well arranged, well illustrated and up to date. It should be valuable to the medical student as a text and to the practitioner for quick reference. Doctor Major has presented a wealth of material as concisely as is consistent with clarity.

—L. H. R.

(Continued on Page 18)

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BOOK REVIEWS

(Continued from Page 16)

Surgical Treatment of Hand and Forearm Infections. By A. C. J. Brickel, M. D., Departments of Anatomy and Surgery, Western Reserve University. Cloth. Pp. 300, with 166 text illustrations and 35 plates, including 10 in color. Price, \$7.50. St. Louis: The C. V. Mosby Company, 1939.

In this book, in the first sixty-seven pages, the anatomy of the hand is described with particular attention paid to boundaries of fascial spaces and aspects concerning infections, pathways, and limiting barriers. A chapter deals with portrayal of tendon sheaths and spaces by x-ray after injection. Then come 190 pages, mostly on the subject of clinical surgery.

The part dealing with the anatomy is well done and gives a somewhat different approach from the usual. Ten colored plates are excellent. The sheath injections are as usually shown, though the author concludes that the conventional middle palmar space is nonexistent. Of the incisions listed, some are good and others break the rule to never cross a flexion crease at a right angle. The clinical part of the book is so much taken up with narration of individual cases that there is a long journey for the reader between the scattered valued statements. Infections of the wrist joint, which are so important, are barely touched. One feels a desire for riper experience and more concise portrayal in the clinical field, though the part of the book dealing on anatomy has much merit.—Sterling Bunnell.

Menstrual Disorders. Pathology, Diagnosis, and Treatment. By C. Frederic Fluhmann, B. A., M. D., C. M., Associate Professor of Obstetrics and Gynecology, Stanford University School of Medicine, San Francisco, California; Assistant Visiting Obstetrician and Gynecologist to Lane and Stanford University Hospitals; Fellow of the American Gynecological Society. Cloth. Pp. 329, illustrated. Price, \$5. Philadelphia: W. B. Saunders Company, 1939.

This comprehensive monograph is an excellent work, the first half dealing, not with the disorders of menstruation,

but with the normal process of the function. This part is devoted to an historical review followed by a detailed description of the morphologic and physiologic changes, with the hormonal control of the function.

The latter half of the book deals with abnormalities of menstruation, with great emphasis on the endocrine phase. The logical arrangement makes it useful as a ready reference book, as it clearly gives incidence, etiology, pathology, clinical manifestations, diagnosis, prognosis and treatment in each condition, with special mention of the hormonal cause.

The many splendid histopathological illustrations, the pictures of hormonal control of menstruation, and the graphs are clear and simple and the bibliography is most complete.

On the whole, this is a very valuable book for the general practitioner.—V. J. E.

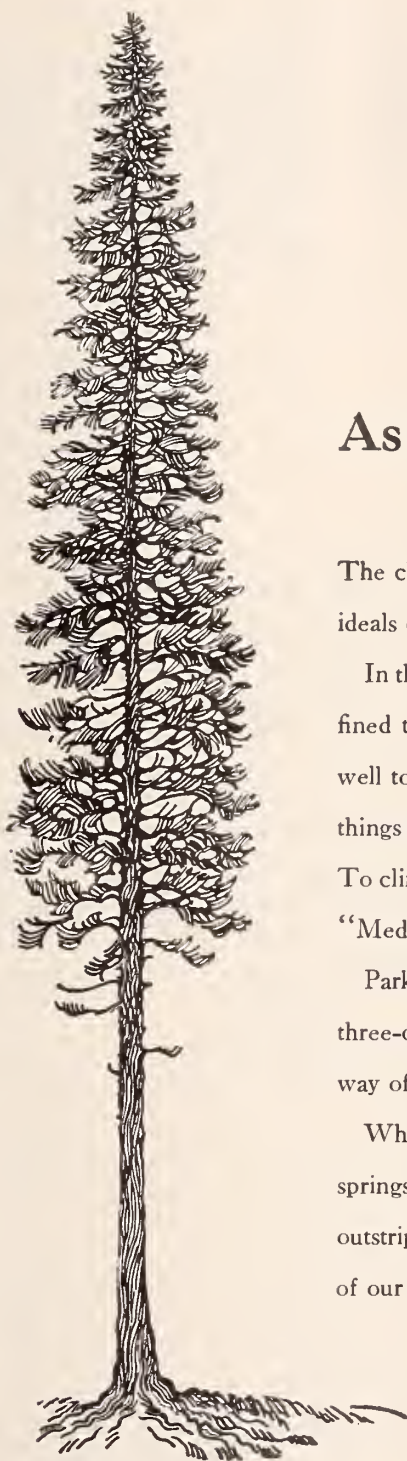
Hugh Young: A Surgeon's Autobiography. By Hugh Hampton Young, A. B., M. S., M. D., Professor of Urology, James Brady Urological Institute, Johns Hopkins Medical School, Baltimore, Maryland. Cloth binding. Price, \$5. Pp. 538. One hundred three anatomical drawings by William P. Didusch, together with various photographic illustrations. New York: Harcourt Brace & Company, 1940.

"Why write of my life," is the question asked and answered in the preface of "Hugh Young: A Surgeon's Autobiography." The most cogent reason perhaps was the insistence of friends, but the hidden motive, "a chance to tell of the fine time I have had"—and he ends the story, rich in adventure, experience and spicy anecdote, "Need I say more to show how much I have enjoyed the life I have led, or what a thrilling time I have had in my professional work? But there is still so much to do, so much to live for." To be up and at it, to do something, and to enjoy life in the doing is the essence of the life of this human dynamo.

"As old as your arteries" is a medical truism, and Osler was wont to assign as the common cause of early senility, a too enthusiastic worship of Vulcan, Bacchus, and Venus. Yet here is one still vigorous and active at seventy, who by his own word admits being a zealous, strenuous, and lifelong follower of these deities.

(Continued on Page 20)

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BOOK REVIEWS

(Continued from Page 18)

The medical record, by no means fully given autobiographically, displays an energy and activity to put Vulcan's forge to shame. A scholarship won at first try on entering the University of Virginia, the editorship of "College Topics" (an experience with a lasting influence), in addition to an overcrowded schedule in the second year; completion of all scholastic work for the B. A. and M. A. degrees and the full first-year course of medicine in the third year; graduation in medicine the fourth year—three degrees, B. A., M. A., and M. D., in four years—this is an unheard-of pace for a starter in life.

At twenty-seven, he was appointed by Halsted, to "take charge of the Department of Genito-Urinary Surgery," being told, "Welch and I said you don't know anything about it, but we believe you can learn." Just then an attack of jaundice put him down. With all the books he could get on the subject, he left the hospital for two weeks to recuperate. In that fortnight, he had read them all and re-read "the splendid system of Prince A. Morrow." "I owe much to that attack of jaundice," he says, naively intimating mastery within two weeks of the subject to which he had been appointed departmental head. And this pace is characteristic of his subsequent career. "The urge to pursue interesting problems and to write and lecture about them has been an ever-present motive force. In fact, if two or three weeks go by without my becoming engaged in the preparation of some manuscript, I have a distinct feeling of unrest."

A glance at the record reduces this seeming boast to cold fact: Young has written six books and over three hun-

dred medical papers. He has hand-trained forty-four specialists and, in addition to this individual family group in which he takes pride, he has inspired and instructed for shorter periods, hundreds of others, most of whom regard him as their master, though their training was not completed under him.

Few of us who hammer, hammer at the forge day and night, year in, year out, ever accomplish half as much. Without the record of this amazing amount of work, the surgical account of which is beautifully illustrated by Didusch, an outsider would see in this self-portrait only a charming man of the world, a bon vivant. How fortunate that when he came to write about himself, he asked his friends and publishers, "What about the medical work on which I have spent most of my time and effort?" and they answered, "Tell the complete story." It may be a little "lusty and gusty," as *Time* put it, but the "true picture" is not sacrificed. Nowadays, free discussion of sex and genital ills, of which it abounds, is quite acceptable. "And so I tell the most important happenings in my medical career." How he nursed the sickly, detested outcast of medical practice—the infant, genito-urinary surgery—which was then nothing more than venerology, into the enviable stature of a vigorous surgical specialty can be read, however, only between the lines. More than any man is he the father of modern urology. As head of venerology, under Pershing in World War I, he "made the underworld safe for democracy."

Throughout this long fruitful medical career he has been ever a man of the world, a worshiper of Bacchus and Venus, interested in people in the activities of his community, in music, in sports, and always in a good time. His Baccha-

(Continued on Page 22)

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BOOK REVIEWS

(Continued from Page 20)

Italian devotion leaned toward vivacity and fun, not inebriety and remorse. He admits to having been besotted twice. How must Bacchus, "ever fair and young," have chortled when Young "tossed off with baby hands (eighteen months) a large whiskey toddy." "I became uproariously drunk, refused to go to sleep, continued to keep up a perfect carnival of noise and merriment throughout the night," and in the superiority of his seventy years, he adds, "This inoculation against the effect of whiskey probably has stood me in good stead many a time." Liquor, with him was incidental. It was his servant. He could be merry without it. An exceptionally good story-teller, he could be entertaining even at the snack-luncheons with his dumb-bunny assistants. At a party, mixed or stag, with or without the usual all-round complement of drinks, he is an unexcelled after-dinner spellbinder. Pitted against a score of experts at the Family Club once, he gave story for story; of the others' stories, only two were new to him, whereas six of his stories none of them had even heard.

His second admitted inebriety was at the Havana Yacht Club, following the ritual of twelve Bacardi cocktails preceding Soiland's honorary commodoreship. Young remembers, so he writes, "eight rounds of 'no heel taps, down' and the next thing I knew I was on board ship. My memory is not clear about the latter part of the ritual or the ceremony." It is unlikely that these drinks stole away his brains. He may have been hilarious, sottish never, and so cheeriness has nullified the evils assigned by Osler.

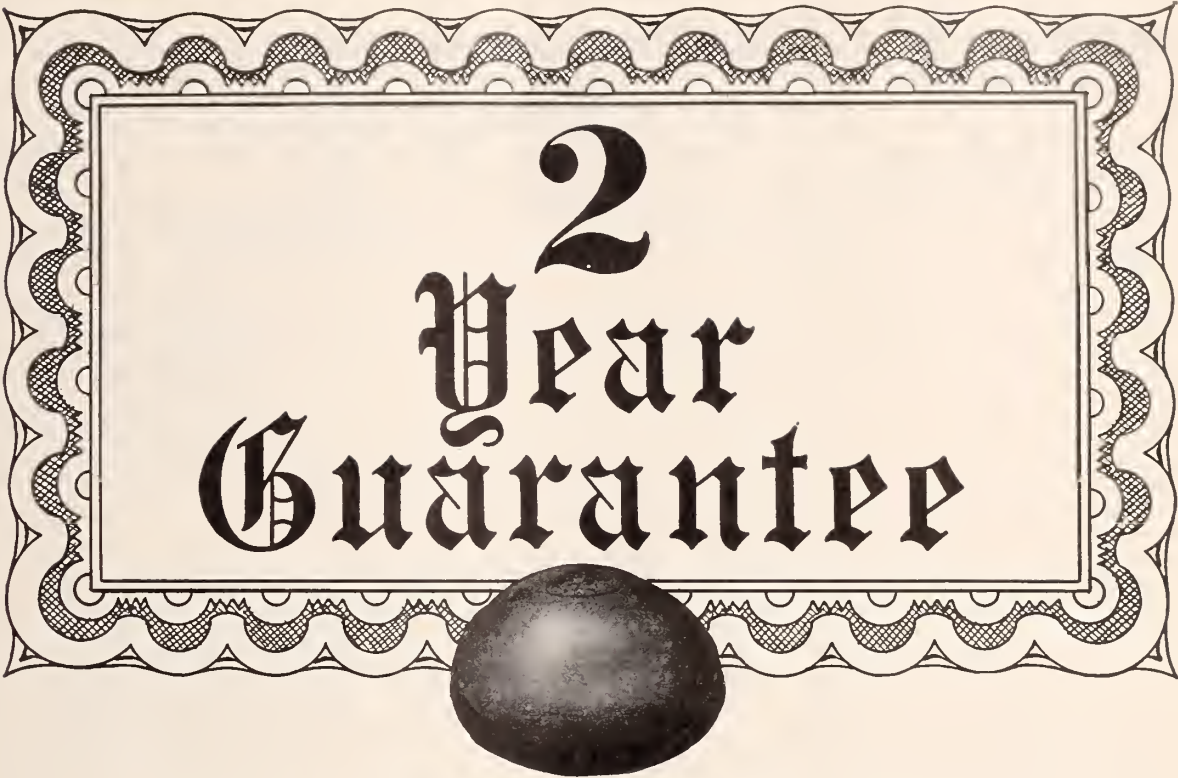
Young's worship at the shrine of Bacchus, while wholehearted as in everything, has been a blessing, not a blight in his life.

And to go on with Osler's mythology: One's expectation of a delectable tale of homage to the goddess, as good as or better than Casanova's, is disappointed. There can be no question of gallantry and masculine charm freely displayed on occasion, but the worshiper has been wary and wise. Discretion, no doubt, saved him time and again at the very brink. His urge was rather the love of fun and amusement than the serious winning of hearts. How many he broke is not mentioned, but he pictures what his friends saw—a happy contented married life. The untimely death of Mrs. Young was a grievous loss.

"At the age of six, I had a sweetheart," he writes, and sixty years later, on the cruise to South America, he describes an affair, more or less typical of many, with "Portia, a charming young woman who had just returned from Paris, where she had sung in the Opera Comique. Her lovely Paris gowns attracted attention at once. She was amusing and gay, and we became fast friends." (It was rumored here at home they were to be married.) Anyway, she inspired poesy which unlocks hearts and one, "To a Pet Turtle," which Portia "led around the deck on a pink ribbon," is given in full. One other written at this period, with thoughts in line, was read at his farewell dinner on the steamship *Van Dyke*. He may have written others. Anyway, Portia gave him many thrills—a real one when he rescued her from a boa constrictor—minor experiences in acting as keeper to the poisonous reptiles, parrots, and monkeys, not forgetting the turtle of her private menagerie.

(Continued on Page 24)

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BOOK REVIEWS

(Continued from Page 22)

Knowing his devotedness to the fair sex, Heitz-Boyer of Paris inveigled him to take the long, tiresome trip from Madrid (International Society of Urology meeting of 1930) to Marrakech, in Morocco, which he did by way of Rome, there "to deliver a lecture," returning to London in time for a scheduled address. "He (Heitz-Boyer) painted a picture of the palace where we would be entertained and the harem with two hundred beauties into which he would take me." Young tells many amusing and thrilling experiences of this trip, but later Heitz-Boyer "admitted that his promise of a visit to the harem was simply put out to lure me."

One can guess on reading this autobiography why Osler's dictum misses Hugh Hampton Young. He worked for joy, drank for fun, and loved beauty and wit for amusement. Work without a worry, drink without a curse, and women without remorse hardens no arteries, and now at seventy he is as active, interested and interesting as ever.—Frank Hinman.

TWENTY-FIVE YEARS AGO

(Continued from Text Page 310)

member not reported and paid for before March 1, is recorded as dropped from the first day of the year and is put back as a new member from the date when, and if, he is again reported. He loses all right to medical defense during the time between January 1 and the date when he is reported, after March 1. Suits for damages for alleged malpractice are increasing so rapidly that no member can afford to be without the protection of the State Society for a single day. Be sure to pay your dues early and avoid trouble.

Danger Averted.—The wisdom of referring the names of all applicants for membership in county societies to the office of the State Society for a report before taking any

action, was emphatically illustrated quite recently when the secretary of a certain county society sent in the name of one Frank B. M—— as an applicant. The records disclose but one of this name licensed in this state. They also disclose the fact that the person of this name was an advertising specialist in "men's diseases" and "blood diseases" on Third Street, near Market Street, San Francisco, and that there were many nasty cases reported about him. The activities of the Board of Medical Examiners made it very uncomfortable for him and so, presumably, he decided to be good and get all whitewashed so he would look nice and clean. Wouldn't he make a nice member!

1 1 1

Taxing Physicians.—A prominent member of the Society writes as follows: "Can a city legally collect a business license tax from a licensed physician, in this state"? It can. There are a number of supreme court decisions on this point, one of them here in California. Furthermore, we find in Blackstone's Commentaries, Book III, Chapter 9, 158: "For it is a part of the original contract, entered into by all mankind who partake the benefits of society, to submit in all points to the municipal constitutions and local ordinances of that state, of which each individual is a member. Whatever, therefore, the laws order anyone to pay, that becomes instantly a debt, which he hath beforehand contracted to discharge." This is fundamental common law, and provided the local ordinance is not so worded as to discriminate against persons of the same class, and that it does not conflict with a superior statute, it is good and valid. . . .

1 1 1

Social Insurance.—In view of the fact that the Journal, from the time that industrial insurance was first broached in this state, expressed the opinion that it was merely the

(Continued on Page 26)

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**Medical Record, Aug. 21, 1940*

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TWENTY-FIVE YEARS AGO

(Continued from Page 24)

forerunner of general sickness insurance, the following (infra) editorial from a recent number of *The Journal of the American Medical Association*, is interesting. It is a safe bet that this further sociologic change will be along within the next five years, but by that time we will have learned many things as to social insurance from our experience with industrial accident and occupational disease insurance, both of which we now have with us: . . .

✱ ✱ ✱

Photographs, Please!—On several previous occasions we have referred briefly to the records concerning physicians which are being gathered in the office of the State Society. The desire is to secure and file away all the information it is possible to get about any and every physician in California. It is exceedingly valuable, the commendatory information no less than that which reflects unfavorably. The question of identity has come up on a number of occasions, and in one instance several weeks were required before we could obtain a certain sample of a physician's writing in order to identify a signature to an official document. You have no idea of the importance of this apparently trivial thing of absolutely fixing the identity of a certain individual. For that reason we are filing, as fast as the work can be done and the material secured, samples of handwriting, photographs, etc. Will you please send us your photograph? Preferably, an unmounted one, with your signature on the back; but any sort of photograph will do. We have a few hundred photographs and they come in very handy; we want all we can get; will you help? Please do.

Ray Lyman Wilbur, M.D., Country Doctor, President of Stanford.—The backbone of the medical profession is not the city specialist or the wonderfully able surgeon; as the *Journal* has always contended, it is the country doctor who is thorough, careful, and conscientious; who works hard and studies hard and who has a large conception of humanity and of human nature and frailty. It is, therefore, a very great pleasure to record the appointment of Dr. Ray Lyman Wilbur to the presidency of one of the large universities of this country—Leland Stanford, Jr., University. The opportunity has been given him to extend his work and his activities into a very large field and the knowledge and the training which he acquired as a good "country doctor" will enable him to be very useful to the institution whose future destinies and policies he is largely to guide and shape. It would probably be conventional to compliment Doctor Wilbur upon his appointment; but would it not be more fitting to felicitate Stanford University and to compliment the medical profession and particularly the country doctor upon this recognition of what it, and the type, may stand for in the community?

From an Original Article on "Amputations and Their After-Treatment," by L. Eloesser, M.D., San Francisco.—The subject of amputations is one that up to recent years has long been neglected and overshadowed by more important modern achievements in abdominal, thoracic and cranial surgery. We can glean more useful information from older surgical writers—Velpeau and other old French and English surgeons—than from the more modern textbooks. Of course, these writers of a day when amputations made up more than half of all major surgical procedures, had a vastly greater experience than we whose knowledge

(Continued on Page 28)

STUDIES IN THE AVITAMINOSES



This page is the final of a series on vitamin deficiencies presented by the research division of The Upjohn Company because of the profession's widespread interest in the subject. A full color, two-page insert on the same subject appears in the December 7 issue of The Journal of the American Medical Association.

The Exacerbation of LATENT PELLAGRA by Acute Infections

Vitamin requirements are increased by many factors, especially by acute infectious disease. Field, commenting on this phenomenon, states that the onset of pellagra may coincide with pregnancy, organic gastrointestinal disease, severe and prolonged illnesses, and dietary restriction for therapeutic purposes. The patient whose tongue is shown developed this manifestation of pellagra during the course of lobar pneumonia. After nicotinic acid therapy was started she coughed up a cast of the esophagus which consisted of a grey membrane similar to that covering the tongue. The pellagrous symptoms responded promptly to treatment.

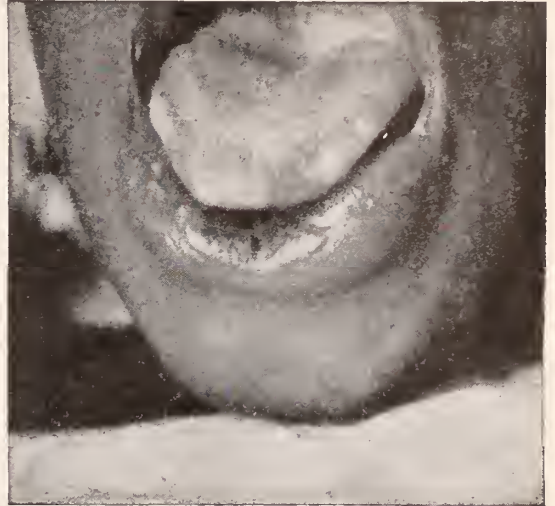


Illustration courtesy of Virgil P. W. Sydenstricker, M.D.,
University of Georgia Medical School, Augusta, Ga.



Illustration courtesy of Virgil P. W. Sydenstricker, M.D.,
University of Georgia Medical School, Augusta, Ga.

The Coexistence of Vitamin Deficiency States

Many authors have recently presented evidence that vitamin deficiency states often are multiple. Strauss has called attention to the fact that deficiency disease in man, unlike that experimentally produced in animals, is rarely limited to a single factor. The patient whose hands are shown had partaken of a markedly deficient diet for several months. As a result, scurvy and pellagra developed concurrently. The ecchymoses of the former and the dermatitis of the latter are clearly visible. Specific therapy together with dietary adjustment led to prompt remission of these signs.



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TWENTY-FIVE YEARS AGO

(Continued from Page 26)

of the treatment of wounds and chronic inflammations of the bones and joints has enabled us to save many limbs that were formerly sacrificed. Our results in amputations, however, lag far behind those in other surgical procedures. . .

From an Original Article on "The Application of Anoci Association to Obstetrics," by Carl L. Hoag, M. D., San Francisco.—The present furore about "twilight sleep" has brought great pressure to bear upon the conscientious physician who does not feel justified in using a procedure which entails such risks. Recognizing the general demand for the more extended use of anesthetics in labor, he will doubtless welcome any method which secures this end without too much danger to mother or child. This consideration has prompted me to report the following procedure without awaiting the accumulation of a large number of cases. As will be seen, the method is not new in itself, but is the application of a now well accepted principle to this new field of obstetrics. . .

From an Original Article on "The Treatment of Congenital Syphilis," by Hans Lisser, M. D., San Francisco.—When one has the opportunity of seeing large numbers of luetic patients that drift in from widely scattered sources, a large number of whom have already received some specific medication, it is somewhat disappointing to note how varied and unsystematic the majority of such treatment proves itself to be. Some of these failures are unquestionably to be referred back to the individual patient, who is either too ignorant to comprehend the necessity for vigorous long-continued treatment, or unwilling to follow the earnest advice of his physician. Despite these extenuating

circumstances, and the deceptive promises of quacks, a goodly amount of rather haphazard treatment must be admitted by the profession itself. This is somewhat surprising in view of the extraordinary efficacy of the remedies at our command. And yet this very brilliance of result is occasionally a stumbling-block, the patient regaining his health so rapidly that he firmly insists he is cured. The treatment of acquired syphilis has become, for the present at least, quite standardized. The combination therapy of old salvarsan, and mercury salicylate injections with the judicious use of the iodids is, if properly administered, almost ideal. It is certainly eminently satisfactory.

From an Original Article on "Dr. Carlos J. Finlay, Discoverer of the Theory of the Transmission of Yellow Fever by the Mosquito: His Biography," by Dr. E. B. Barnett.—In view of the fact that one of the most brilliant discoveries of the age (fully as important to tropical America as that of the immortal Jenner), the transmission of yellow fever by the mosquito, was made in Cuba, and that with this discovery is connected the name of the eminent Cuban physician, Dr. Carlos J. Finlay, and on account of his recent death it would appear opportune at this time to go into the life history of this illustrious man. His death occurred in Havana, Cuba, on August 20, having reached the age of eighty-two years.

The work of Finlay has opened up the heretofore closed path of progress and civilization in tropical America. Without detracting in the least from the merits of Doctors Reed, Carroll, Agramonte, Lazear, Gorgas, and others, who contributed in the practice of exterminating the mosquito as a measure of sanitation, it is possible to declare that without the Finlay theory, the gigantic work of the Panama Canal could never have been accomplished.

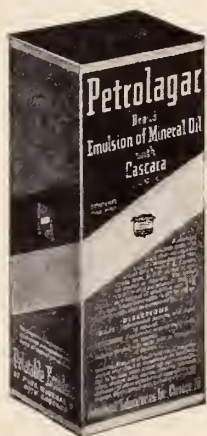
(Continued on Page 30)

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San Francisco

TWENTY-FIVE YEARS AGO

(Continued from Page 28)

The same sanitary plan which was carried out in Cuba was enforced at the Canal Zone, thus confirming the ideas of this brilliant mind.

In an address delivered at Baltimore in April, 1901, Dr. Walter Reed made the following statement: "To Dr. Carlos J. Finlay must be given, however, full credit for the theory of the propagation of yellow fever by the mosquito."

BOARD OF MEDICAL EXAMINERS

(Continued from Text Page 310)

Graduates of foreign medical schools must have fulfilled requirements in our Forms 172-173 before filing application.

It is imperative you notify Sacramento office of Board (in writing) at time of filing application when and where you will appear for written examination.

♦ ♦ ♦

At the regular meeting of the Board of Medical Examiners held at the State Capitol, Sacramento, October 21 to 24, inclusive, 1940, approximately seventy-seven applicants of all classes, including physicians and surgeons, chiroprodists and drugless practitioners, wrote the examination for their respective certificates. Among the physicians and surgeons were several graduates of foreign medical schools.

The following changes in status of the various licenses were made:

The license of Perlely B. Exelby, M. D., revoked on October 18, 1939, was restored on October 21, 1940, and he was placed on five years' probation.

The license of Thomas D. Wyatt, M. D., revoked on October 19, 1939, on two counts of alleged illegal operation, was restored on October 23, 1940, and he was placed on probation for a period of five years.

Archibald E. Amsbaugh, M. D., charged with allegedly prescribing for narcotic addicts, was on October 23 placed on five years' probation, during which period he is not to have or apply for a federal narcotic permit, or have narcotics in his possession.

Clyde Rolland Bennett, M. D., charged with conviction of a crime involving moral turpitude, was on October 22, 1940, placed on five years' probation, the terms of which were specified.

Robert E. Benveniste, allegedly violating the narcotic law, was on October 23 placed on five years' probation under certain terms, which specified that within ten days he must close his office for a period of ninety days. Doctor Benveniste has filed petition for writ of mandate in the Superior Court of Los Angeles County. Petition is set for hearing before said court on December 20, 1940.

Edwin Morey Chase, M. D., charged with allegedly habitual intemperance, was on October 23, 1940, placed on probation for a period of five years.

Walter Blaine Felger, M. D., charged with aiding and abetting, was on October 23, placed on probation for a period of five years under specified terms.

James T. George, M. D., charged with allegedly violating the narcotic law, was on October 23 placed on five years' probation under specified terms, among which was that he must within ten days close his office and give up practice for a period of ninety days.

Arthur Richard Gould, M. D., charged with aiding and abetting, was on October 23, 1940, placed on three years' probation under specified terms.

(Continued in Back Advertising Section, Page 34)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

CANNED FOODS IN THE MODERN PATTERN OF NUTRITION

● Generalities as to human nutritive requirements are of but limited use in the practical application of our modern knowledge of nutrition. This is particularly true where expert and experienced advice on diet formulation is not readily or conveniently available. For those concerned with actual diet planning or administration, more specific information on nutrition is desirable.

During recent years, several excellent texts have become available which present reliable guidance in diet planning (1, 2, 3). One important factor governing conformance with any diet pattern, of course, is the economic status of the individual, family, or group. A recent text presents a workable system in which rather full consideration has been given to this factor (1).

Under this pattern, the common foods have been classed according to their nutritive contributions into some 12 groups. These groups include milk; potatoes and sweet potatoes; mature dry legumes and nuts; tomatoes and citrus fruits; leafy green and yellow vegetables; other vegetables and fruits; eggs; lean meat, poultry, and fish; flour and cereals; butter; other fats; and sugar. There will, of course, be quantitative differences in the nutritive values of individual foods within a single group. However, there is sufficient similarity so that the foods within a group can be used interchangeably as conditioned by factors such as availability, relative costs, and personal, racial, or religious preferences. In order to minimize variation of nutritive values obtained from each food group, it has been suggested that as wide a variety of foods within a group, as practical, be consumed.

In connection with this diet plan, desirable yearly food allotments for persons of various sex, age, or conditions of life are also listed in terms of these twelve food

groups. Thus, from information regarding the sex, age, and activities of the members of a family or group, one can compute the yearly amounts of the various foods which should be provided. From the sum of these yearly totals, the food allowances per week or month for the family or group can be estimated. The latitude in the choice of foods, within the twelve specified food groups, makes the diet pattern more adaptable to situations where the economic factor must be considered.

Estimation of food requirements in this manner provides a practical method of diet planning designed to supply the nutritive requirements of an individual, a family, a group, or even a nation. However, the ultimate achievement of an improved nutritional status is dependent upon a readily available supply (at all times) of the various common foods at reasonable cost. It is apparent from the listing of the twelve food groups that many materials of a perishable nature—which are not conducive to year-round production near the centers of large populations—are indispensable in supplying the dietary requirements of our people. Thus, the transportation and storage of foods, in such a manner as to retain nutritive values, are important problems to be considered.

Needless to state, commercially canned foods are well adapted for use in this diet plan. Commercial canneries are located near the sites of abundant supply of freshly harvested foods. The canning processes convert the perishable foods into nutritious canned foods which can be economically transported and marketed throughout the year. Hence, the canning industry plays an important role in the practical aspects of diet planning to improve the nutritional status of the American people.

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REFERENCES

1. 1939. Food and Life; Yearbook of Agriculture, U. S. Dept. of Agriculture, U. S. Govt. Printing Office, Washington, D. C.
2. 1939. Accepted Foods and Their Nutritional Significance, Council on Foods of the American Medical Association, Chicago.
3. 1940. J. A. M. A. 114, 548.

We want to make this series valuable to you, so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned-foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles. This is the sixty-sixth in a series which summarizes, for your convenience, the conclusions about canned foods reached by authorities in nutritional research.



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CALIFORNIA AND WESTERN MEDICINE

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Secretary-Editor, ex officio	

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Responsibility for Statements and Conclusions in Original Articles.—Authors are responsible for all statements, conclusions and methods of presenting their subjects. These may or may not be in harmony with the views of the editorial staff. It is aimed to permit authors to have as wide latitude as the general policy of the Journal and the demands on its space may permit. The right to reduce or reject any article is always reserved.

Contributions—Exclusive Publication.—Articles are accepted for publication on condition that they are contributed solely to this Journal. New copy must be sent to the editorial office not later than the fifteenth day of the month preceding the date of publication.

Contributions—Length of Articles: Extra Costs.—Original articles should not exceed three and one-half pages in length. Authors who wish articles of greater length printed must pay extra costs involved. Illustrations in excess of amount allowed by the Council are also extra.

Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

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EDITORIALS†

GREETINGS FOR THE NEW YEAR

In Retrospect.—At this writing, in the period between the two nowadays Thanksgivings, it is natural that thoughts should turn to blessings received; and on the eve of another Christmas and the advent of a New Year, it is also in order to express the felicitations of the season. These good wishes, then, CALIFORNIA AND WESTERN MEDICINE extends to all.

It is gratifying to be able to report that the work of the Association has gone forward in excellent fashion; and particularly, that California Physicians' Service, sponsored by the California Medical Association, is on a self-sustaining basis.

In January, a new Congress will convene. To what extent legislation, partaking of the nature of state or socialized medicine, may be submitted, it is not possible to forecast. It may be assumed, however, that the proponents of certain measures, such as the Wagner Health Act, will not be backward in again advancing their claims for the enactment of that or a similar law.

In California, on the first Monday in January—the sixth day, by the way, of the month—the Legislature will convene. In recent statements, Governor Culbert L. Olson has furnished evidence he will again give vigorous support to proposed compulsory health legislation. Last year, in the Legislature, the threat of an initiative for such a law, to be placed on the November, 1940, ballot, was made; but the initiative did not appear. That, however, does not mean that the advocates will not be busy at Sacramento. In due time their proposals must be brought out into the open.

Medical Preparedness plans in California are being carried through in satisfactory manner. The medical profession may take pardonable pride in the willingness of its members to lay aside private practice, and to do their part in Medical Defense preparations. Yet it is important for all physicians, both men and women, to respond as promptly as possible when called on for needed information to make it possible that the best of professional service, and at all times, will be available not only in military activities but in civil practice.

All in all, the year 1940 seems approaching its end for the medical profession very satisfactorily.

† Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

The vantage positions gained should permit all to look forward with fair assurance of victory for all measures designed best to promote the conservation of health and life.

Again, from your OFFICIAL JOURNAL: Greetings and Good Wishes for the Christmas Season and the New Year!

ANNUAL REPORTS OF COUNTY MEDICAL SOCIETIES IN THIS ISSUE

Value of Annual Reports from Component County Societies.—At a recent meeting of the Publication Committee of the OFFICIAL JOURNAL the conclusion was reached that an annual progress report by each of the forty component county units of the California Medical Association could be made of more value than the printing, month by month, of meeting minutes from a small number of county medical societies.

In this December issue, therefore, the plan of a progress survey is having its initial try-out, and the attention of members is called thereto; officers and members of program committees being particularly requested to scan the reports. (See page 290.)

In this connection it is gratifying to note from letters received that some of the county societies are alert, not in a few, but in all their responsibilities. The reports are worthy of perusal by all who are interested in the progress of organized and scientific medicine, and the Publication Committee and Editor express their thanks for the generous coöperation given by county secretaries who have contributed to the survey.

CALIFORNIA INDUSTRIAL ACCIDENT COMMISSION RESOLUTION OF OCTOBER 16, 1940, MAY HAVE WIDE RAMIFICATIONS FOR PHYSICIANS AND HOSPITALS

Resolution and Correspondence Should Be Read.—Members of the California Medical Association may well take the time to read the Resolution adopted on October 16, 1940, by the California Industrial Accident Commission, which appears, with related correspondence in this issue of CALIFORNIA AND WESTERN MEDICINE. (See page 273.)

W. F. Beem's letter of November 15, 1940 (Item VI in this series, as printed), states that the resolution will not be literally enforced. However, the resolution still stands; and its phraseology and implications, which make it a menace to property rights and confidential or privileged physician-patient relationship, are presumably violations of the Constitution of California and to court decisions relative to the same.

In reading the resolution and correspondence, physicians have a just right to query the action taken by the Commission, as indicated in the resolution, and also in the interview quoted from the *San Francisco Recorder*—a publication primarily for circulation to members of the legal profession—in which Chairman George G. Kidwell of

the State Industrial Accident Commission comments on the scope and nature of the Commission's actions. (See Item II, on page 274.)

* * *

Resolution May Make for an Increase in Malpractice Cases.—It is important to keep in mind that if this resolution remains among the rules of procedure and practice of a state body, such as the California Industrial Accident Commission—a rule practically permitting attorneys or representatives of industrial patients to have preliminary access to records of physicians and hospitals before hearings are held—it may soon be cited and accepted as standard practice by one or more courts in which malpractice cases of a civil nature are being heard. It needs no great imagination to conceive how similar court decisions in civil cases in private practice may lead to malpractice suits without end.

It is generally agreed that statutes or rules that cannot be or are not enforced are better off than on the statute or other books; and this opinion should apply to a quasi-judicial body such as the State Industrial Accident Commission.

Members of the California Medical Association will find the resolution and correspondence of special interest.

PRINTED REPORTS OF PUBLIC HEALTH DEPARTMENTS AND PUBLIC HOSPITALS

Comments on Massachusetts and California Health Reports.—Receipt recently of the Annual Report of the Department of Public Health of the Commonwealth of Massachusetts for the year ending November 30, 1939—containing 289 pages—led to an inspection of the last printed report of the Department of Public Health of California—that for the fiscal years from July 1, 1936 to June, 1938. California in this, its thirty-fifth biennial report, needed only 275 pages to portray its activities, or 138 pages for a single year, in contrast to the 289 pages in the Massachusetts report, although California exceeds Massachusetts in population by more than two million persons. In density, true, Massachusetts had an approximate population of 528 persons per square mile to California's 36.*

The reports of the two state departments should be of special interest because Massachusetts and California were the first commonwealths to establish, in 1870, state health departments, the Massachusetts statute for establishment antedating that of California by only a few months.†

* * *

Postgraduate Courses in Massachusetts Receive Federal Aid.—An item, also of added interest in the Massachusetts report, is the notation of a federal grant-in-aid, in 1939, of \$7,634 for "postgraduate instruction," concerning which the following was stated:

"(a) *Postgraduate Courses for Physicians.*—The Department again coöperated with the Massachusetts Medical Society in providing postgraduate courses for physicians.

* United States Census figures for 1940, since released, give 6,907,378 as California's population, and 4,316,721 as population of Massachusetts.

† For historical references in CALIFORNIA AND WESTERN MEDICINE, see issue of January, 1940, page 2.

In the spring and fall these lectures were carried on in eighteen different centers in the state. There was a total attendance of 984 physicians this year."

Similar grants of federal monies were made to a number of other states; and the question arises, Why should not California avail itself of such funds? Acting together, the California Board of Health and California Medical Association could give a real impetus to postgraduate courses for physicians. It is, therefore, gratifying to announce that conferences are under way for that purpose.

* * *

Public Boards and Institutions Should Print Annual Reports.—In connection with the subject of printed reports, it may be in order to emphasize the value of such documents:

(1) By permitting the governing board of an institution that expends tens of thousands of dollars each year, to maintain for comparison, both for its executives and also for the citizens who supply the funds, a record of its activities and the expenditures in connection with each; and

(2) By making it possible for similar bodies to study procedures that may result in economy of funds and effort, or which will promote in highest degree the attainment of the objectives for which the departments or institutions exist.

* * *

Political Authorities Are Loath to Print Reports.—In political circles, officials in charge are not infrequently reluctant to expend public funds for printed reports, their usual excuse or argument being "economy." Observation of such attempts at saving leads to the conclusion that the funds supposedly so conserved not only actually fail to make for saving but not infrequently lead to wastage.

Two examples may be permissible:

(1) Some years ago, the Board of Supervisors of Los Angeles County refused to build and try out, to determine whether defects existed, a one-story type of the ward plan—later incorporated in the seventeen million dollar unit of Los Angeles County General Hospital—that could have been built for about ten thousand dollars. In the light of the subsequent massive expenditures for the construction of that monolithic structure, it became evident, unfortunately too late, that the so-called initial saving of public funds did not make for the protection of the taxpayers' money; and

(2) The action of the same authorities in contracting for a call-system for physicians, to be installed in the new building—a system chosen without consultation of the medical advisory board, and contracted for at a cost of almost one hundred thousand dollars—likewise was not a saving of public funds, since the system contracted for was not workable, most of the equipment being junked, although later salvaged in part through sale for less than ten thousand dollars! If printed progress reports on the hospital planning had been made and submitted to public scrutiny, some of the later

expensive errors that were incorporated in this most expensive of all single hospital structures in America might have been prevented.

Strange to relate, this same Los Angeles County General Hospital, with an annual appropriation for its maintenance in excess of five million dollars (not counting the money value of the gratuitous medical and surgical services rendered by several hundred physicians who are members of the attending staff), has not in years printed an annual report! Not that requests for such printed reports have not been made by representatives of the attending staff; for such petitions were repeatedly submitted through action of the Medical Advisory Board, when, always, practically the same answer came back, "Sorry, but no printing funds are available this year."

* * *

Money Value of Professional Services Rendered in Public Hospitals.—It has been estimated that the money value of the gratuitous services rendered by members of the attending staff of the Los Angeles County General Hospital is in excess of two million dollars. Thus, the physicians of the County of Los Angeles give professional services having a money value much in excess of the total funds raised through donations from all taxpayers for the Community Chest. Nevertheless, according to the political authorities, there is never available any money for a report on the medical and surgical work of the institution! As a result, many of the thousands of patients and citizens are under the impression that the members of the attending staff are all on salary. Certainly, a state of affairs, that cannot be construed as proper appreciation for valuable services rendered!

Is it possible to think of any other group of citizens who would thus conceal the nature of their services so generously rendered? When the Community Chest campaigns are on, are not all the prominent citizens who attend meetings given repeated praise in the press? In contrast, how utterly lacking or sparse in amount are the expressions of thanks to the men and women physicians who, year after year, unostentatiously give of their best to the poor of the community who are housed in the County Hospital!

* * *

Legal Difficulties Concerning Printing of Reports.—Not to be forgotten, concerning the printing of reports, is the fact that public boards must observe legal requirements in the expenditure of all monies. Thus, a board may have the power to spend money necessary to print a report, but antecedent thereto may be a requirement that the item be definitely included in the budget of the year in which the expenditure is to be made. The Los Angeles County Board of Supervisors is expected to observe this rule.

Again, with other bodies such as the Board of Medical Examiners of the State of California, operating under specific statutes, it may not be possible to make an expenditure for certain forms

of printing unless the same are specified in the governing act. Information has recently gone out that the State Board of Medical Examiners must secure from the next Legislature an amendment to the Medical Practice Act, which will specifically authorize that Board to print its annual report and directory, with certain other information contained therein.

Therefore, wherever indicated, steps should be taken to provide for adequate legal authority in these matters.

* * *

Large Public Departments and Institutions Should Print Reports.—Wherefore, why should not printed reports of state agencies, such as the Board of Health, or of large county and municipal hospitals, be printed? The plea of lack of funds is not sufficient. As a matter of fact, reports will make for economies greater in amount than the cost of printing. And surely, when a group of professional men and women annually give gratuitous service having a money value of several millions of dollars, their altruistic endeavors should be rewarded through at least a printed report that could be of scientific worth to themselves, to the institution, and to other communities, also. So slight an expression of appreciation could not only be expected, but should be insisted upon. The medical profession does itself an ill service when it fails to demand proper recognition in such cases.

DEATH TAKES ITS TOLL

Recent Deaths of Prominent Physicians.—The current issue of CALIFORNIA AND WESTERN MEDICINE contains obituaries of several members who, during their years of professional service, left a deep impress upon the communities in which they practiced.* The contributor-friends of the deceased have thus made it possible for readers to acquaint themselves with the lives and work of such men as Lemuel P. Adams of Oakland, Philip King Brown of San Francisco and Guy Cochran of Los Angeles, each of whom entered medicine with a line of forbears who had been disciples of the healing-art guild. It is good to read of these men and others like them who, in the discharge of their daily obligations, were true physicians to the honor of the profession they had espoused and themselves. Younger men may well take the time to peruse the tributes because to read them is to inspire oneself to reaffirm allegiance to a profession which, in power for service to mankind, has no limit.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 273.

* For obituaries, see page 285.

EDITORIAL COMMENT†

DUBOS' "GRAMICIDIN"

The successful treatment of chronic bovine mastitis, by the intramammary injections of Dubos' "gramicidin," is currently reported by Little and his coworkers¹ of the Department of Animal Pathology, Rockefeller Institute, Princeton, New Jersey.

About two years ago, Dubos² succeeded in isolating a Gram-positive, spore-bearing, aerobic soil bacillus capable of lysing pathogenic Gram-positive microorganisms. On autolysis cultures of this soil bacillus yielded an enzyme which, in even minute quantities, would kill or completely inhibit *in vitro* growth of all pathogenic Gram-positive bacteria thus far tested. From this crude autolysate the active principle was eventually isolated: a protein-free, alcohol-soluble, water-insoluble substance, a hundred times more potent than the initial product. Stable aqueous solutions (or suspensions) of this purified "gramicidin" can be prepared by diluting alcoholic solutions with relatively large volumes of distilled water, or 5 per cent glucose.

Preliminary therapeutic tests showed that 0.005 milligram of this purified germicide, injected intraperitoneally into white mice, protect them against 10,000 fatal doses of simultaneously injected pneumococci or streptococci. The gramicidin, however, is almost completely inactive when administered by the intravenous, intramuscular or subcutaneous routes. Its only apparent therapeutic promise, therefore, is as a local antiseptic.

Ideal conditions for its clinical test were seen in chronic bovine mastitis caused by *Streptococcus agalactiae*. This type of mastitis is almost invariably confined to one or more infected quarters of the udder, and is rarely complicated by a demonstrable systemic infection. A number of cases of chronic bovine mastitis were, therefore, selected and studied bacteriologically over a period of several weeks. During this time the number of streptococci remained fairly constant in milk drawn from the infected quarters, the usual count being in the neighborhood of 100,000 microorganisms per cubic centimeter. Following the morning milking at the end of this observation period, the residual milk in the cistern and teat was flushed out with 100 to 200 cubic centimeters of dilute gramicidin, and 800 to 900 cubic centimeters gramicidin solution injected under pressure. The solution was allowed to remain in the infected quarter till the next milking. The routine gramicidin solution consisted of 60 to 240 milligrams of the purified product in 1,000 cubic centimeters of double distilled water.

Within one hour after this injection the treated quarter of the udder became extended, and the

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

¹ Little, R. B., Dubos, R. J., and Hotchkiss, R. D.: *Proc. Soc. Exper. Biol. and Med.*, 44:444 (June), 1940.

² Dubos, R. J.: *J. Exper. Med.*, 70:1-11, 249, 1939; *J. Biol. Chem.*, 132:791, 1940.

rectal temperature began to increase. The temperature usually reached a maximum of about 41 degrees centigrade by the end of five to six hours. The acute swelling then gradually subsided. The rectal temperature usually returned to normal by the time of the evening milking.

In five of the nine cases of streptococcus mastitis thus treated, the microorganisms disappeared completely from the quarter milk after the first injection. The fact that the streptococci had been eliminated was established by a daily bacteriologic examination over periods ranging from fifteen to eighty-one days. In other cases, from two to five treatments were necessary for complete sterilization. Most of these refractory cases were moderately indurated. In two highly indurated cases, repeated injections of the gramicidin markedly decreased the streptococcus count, but failed to sterilize the infected quarter.

No tests of the Dubos "gramicidin" have thus far been reported in human medicine.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

CARDIOTELEROENTGENOGRAPHY

The determination of the cardiothoracic relationship is not a generally uniform procedure among cardiologists and roentgenologists, as established by the various methods in use, and according to the opinions given by a number of eminent roentgenologists and cardiologists.

The methods most commonly in vogue to determine the cardiothoracic relationship are: (a) The transverse cardiac diameter in comparison with the maximum internal thoracic diameter, one-half, a trifle more or less, being the accepted standard; (b) the standard transverse cardiac diameter for weight at a given age; (c) the standard transverse cardiac diameter for height at a given age; (d) calculative determinations in relation to size of heart, the height, weight, and age; (e) and the type of chest, whether sthenic, hypersthenic, or hyposthenic, in relation to cardiac conformation; also Groedel's six-point measurements to establish cardiac dimensions.

Bryant, many years ago, classified the genus homo into three types: (1) The omnivorous, or normal type; (2) the carnivorous, or lean and lanky type; (3) the herbivorous, or thick-set, broad, muscular, and obese type. These types Bryant compared with prototypes of the animal kingdom, as well as setting forth facts, established by hundreds of anatomical dissections, that skeleton and tissue structures of each type were distinctive. And so the heart and thoracic cage must be considered in studying teleroentgenograms.

In connection with the consideration of anomalous types, due cognizance might rightly be given to the opinion of one authority in cardioteleroentgenography, as follows: "It is the opinion that cardiac enlargement or hypertrophy can and does occur without altering the permissible cardiothoracic ratio. It can readily be pictured that a cardiothoracic ratio that would normally be only about 35 per cent, as

occurs in hyposthenic individuals, could easily be hypertrophied to 45 per cent and still be within the so-called range of normal." And those who blindly follow the cardiothoracic relationship, without considering anomalies in cardiac or thoracic cage structure, often err in their determinations.

It should also be remembered that, regardless of the type of cardiothoracic relationship, there are distinctive changes, of varying degree, in the cardiac configuration, resulting from particular prevailing pathology. There is no escape from such pathologic developments.

It appears to be the prevailing opinion "that no one system is absolutely foolproof." And again quoting from the reply of an eminent authority: "... and, after all, the radiologist's experience plays a large rôle in the determination of cardiac changes, as represented in the roentgenogram, and mechanical measurements have not yet superseded this experience."

In conclusion, where the cardiothoracic ratio is used in determining whether cardiac enlargement, with or without hypertrophy, exists, one should avail himself of good judgment and common sense in the consideration of anomalous types.

1155 Jones Street.

JOHN F. MARTIN,
San Francisco.

National Health Library.—The National Health Library, which completed two decades of service this year, announces its removal from the RCA Building in Rockefeller Center to 1790 Broadway, New York City. Since its establishment twenty years ago, this Library has brought together one of the best collections of source material in the United States on public health, sanitation, health education and related subjects. It includes 6,000 volumes and 30,000 pamphlets. More than 500 medical and public health periodicals are received regularly from all parts of the world.

Administered by the National Health Council, the Library is intended primarily for the use of the seventeen health organizations which are members of the Council. Individuals who are not members of the supporting organizations may have the privilege of using the Library by paying a small annual fee.

Members from all over the country avail themselves of the privilege of borrowing books from the Library. Nurses and public health workers in small towns in which there are no libraries are especially grateful for the service. Material may be found at the National Health Library which might take days and even weeks to unearth elsewhere. The indexing of this material makes it of especial value for research workers.

To make the current material useful the magazines are indexed in a card catalog. Every week a mimeographed list of the more important articles is issued under the title: *The Library Index: a weekly index to current periodical literature in the field of public health.* This publication is available to the public for a small annual subscription.

In no place is tuberculosis at so low a level that we may safely, and in the interest of economy, relax the intensity of the tuberculosis control program. On the contrary, because the opportunity for real control of the tuberculosis situation seems more encouraging than ever, this is the time to intensify efforts rather than relax them.—Harry Mustard, M. D.

ORIGINAL ARTICLES

SURGICAL MANAGEMENT OF CARCINOMA OF THE COLON*

By VERNE C. HUNT, M. D.
Los Angeles

ONE may not with authority dogmatize the surgical treatment of carcinoma of the intraperitoneal portion of the large bowel, and at the same time maintain a legitimate mortality rate in his work and favor the patient with the greatest prospect of cure. There is no field of surgery in which individualization is more important; individualization not only of the patient, but of the surgeon as well. Under certain circumstances a particular surgical procedure may be executed by one surgeon with reasonable safety while the same procedure in the hands of another would be extremely hazardous. I know whereof I speak, because I have failed where another might have succeeded.

Many factors are concerned not only in the curability of carcinoma of the intraperitoneal colon, but in the selection of the surgical procedures that may be executed with reasonable safety in the various situations in which neoplastic disease of the large bowel is encountered. So far as curability of these lesions is concerned, if one may ever justly use the term in malignant disease, the stage of advancement of the lesion at the time of its recognition is perhaps most important.

THE DIAGNOSIS

One may hardly discuss the surgical management of carcinoma of the colon without at least brief reference to the problems of diagnosis of this lesion in the various situations in the large bowel. So far as early symptoms are concerned, they may be spoken of as being generally bizarre and characterized by insidious change of bowel habit or function which, it must be emphasized, is not peculiar to neoplastic disease of the colon. Except in childhood and in young adults any change in bowel function should not be lightly dismissed without sufficient investigation to at least exclude neoplastic disease. It has been said many times that obstruction may be the first sign or symptom of carcinoma of the colon. I should like to emphasize the fact that obstruction is never an early symptom of this disease. Disturbance of bowel habit, as increasing constipation or intermittent loose stools, practically always antedates neoplastic obstruction of the colon. It should be carried in mind that usually the lesion must progress to complete or almost complete circumferential annularity before obstruction can occur. In other words, complete obstruction is indicative not of early but usually of advanced neoplastic disease, even though not necessarily indicative of an inoperable lesion. It is worthy of note that approximately 54 per cent of the neoplastic lesions of the intraperitoneal colon occur in the rectosigmoid, sigmoid and descending colon, where

many of them may be encountered on digital, bimanual or abdominal palpation, and where many of them can be proctoscopically visualized. I speak of this to emphasize the fact that the diagnosis may be made or at least suspected by simple means in the hands of all men and women in medicine. So far as the sigmoid flexure and other situations in the colon in which carcinoma occurs are concerned, the competent roentgenologist has established a high degree of diagnostic accuracy through visualization of irregularities in outline and filling defects in the course of or following the barium enema. When one wishes to appraise the reliability of roentgen examination of the colon, one should remain mindful that some limitations must be placed upon the roentgenologist's interpretation of his findings in the rectosigmoid; for this segment has been referred to by Dr. K. S. Davis as the "roentgenologic no man's land."

OPERABILITY

In each case there are a number of matters which must be ascertained in order that one may determine intelligently and accurately the operability of the lesion and the probability of its cure. First of all it is important to determine whether or not the lesion is mobile or fixed and, if fixed and immobile, whether the fixation is due to extrinsic invasion of the lesion or to extrinsic inflammatory reaction. Some idea of the mobility of a palpable lesion often may be obtained through physical examination. In other instances the roentgenologist may determine mobility through palpatory manipulation under fluoroscopic control, as the filling defect is visualized to him in the course of the barium enema. Fixation of the lesion may be a serious matter and even though fixation of the lesion is demonstrated on physical examination or on fluoroscopic visualization, the nature of that fixation can usually be determined only through abdominal exploration. It is worthy of note that fixation does not necessarily denote inoperability, for in many instances that fixation is the result of the inflammatory reaction of protective perforation, and not infrequently under such circumstances the lesion can successfully be extirpated. On the other hand when fixation of the lesion is the result of extrinsic invasion of the growth to retroperitoneal structures, the futility of surgical extirpation has been rather firmly established. It should be emphasized that fixation of a lesion is not an early but rather a late manifestation of neoplastic disease of the large bowel which directs attention to the relationship of early diagnosis, or diagnosis of early disease, to the operability and curability of these lesions.

A second matter which needs to be ascertained in the operability and curability of a malignant lesion of the colon is that of intraperitoneal metastases. In general it may be stated that the operability and prognosis of these lesions depend not only upon the degree of local extension of the disease and the mobility of the lesion, but on the extent of lymphatic metastases, if present, and whether or not blood-borne metastases, particularly to the liver, have occurred. Printy, Jamieson and

* Read at the meeting of the Nevada State Medical Association at Las Vegas, Nevada, October 10-12, 1940.

Dodson, have conclusively shown that a chain of lymphatics accompanies the blood vessels to the colon, and that the pattern of the lymphatic system corresponds closely with the vascular pattern composed of the right and middle colic arteries, and the inferior mesenteric artery and their various branches and ramifications. In the course of an abdominal exploration, the matter of lymphatic glandular involvement usually can be accurately ascertained. Regional glandular involvement, when grossly confined to the main lymphatic chain adjacent to the segment of colon in which the lesion is situated, does not in itself constitute inoperability if the lesion is mobile and when there are no remote metastases discernible, even though such regional glandular involvement materially reduces the percentage prospect of the curability of the disease. The extensiveness of the glandular involvement is important, and certainly a more favorable prognosis may be anticipated when only one or two nodes are involved than when the entire chain which accompanies the vascular pattern is involved in the lymphatic metastatic extension. In my experience regional glandular involvement in varying degrees has been present in approximately one-third of the cases in which radical extirpation of the lesion has been accomplished, with little variation in the incidence of such glandular involvement for lesions in the various situations in the intraperitoneal colon. Although the incidence of glandular involvement has shown little variation in the various segments of the colon, the results in terms of patients living five years after resection without recurrence are approximately 10 per cent better for lesions of the right half of the colon than for those of the left half. The degree of malignancy of the primary lesion is an important factor in prognosis; and while considerable variation in the degree of malignancy exists in lesions in the right and left half of the colon, it is the relative incidence of the grade II lesions of Broder's classification which accounts for much of the more favorable prognosis in lesions of the right colon. Rankin has credited the right half of the colon with 57.6 per cent five-year survivals following radical extirpation of operable carcinoma, and the left half of the colon with 47.7 per cent five-year survivals. It has become a well established fact that the prognosis following radical extirpation of lesions of the colon is best when the growth is situated in the proximal colon and gradually becomes less favorable in each descending segment of the colon from the cecum to and including the rectum.

Inoperability of carcinoma of the intraperitoneal colon is manifested in advanced disease most frequently by invasion of retroperitoneal structures and fixation, metastases to the liver, or generalized metastases to the visceral and parietal peritoneum. In the absence of the clinical manifestations of metastases to the liver, ascites and poor general condition of the patient which preclude operation, operability of an intraperitoneal colonic lesion usually may be determined accurately only through abdominal exploration.

PREOPERATIVE TREATMENT

Experience by this time has proved conclusively that the employment of certain measures for a matter of several days preliminary to operation materially enhances the safety of any surgical procedure on the colon. No one today may avoid justifiable censure who hastily undertakes a radical extirpation of a malignant lesion of the colon before adequate preliminary measures have been instituted. It could not happen here, I am sure; yet within the past six weeks I have observed the antemortem state of an individual who sixty hours previously had entered a hospital under his own power, who forty-five minutes later was on the table and was subjected to a resection for an obstructing carcinoma of the sigmoid, on a hastily arrived-at preoperative diagnosis of adhesions. Obstruction of the colon at times provides urgency for remedial measures, but never may one hastily resort to radical surgical extirpation of a highly obstructive carcinoma for purposes of relieving the obstruction, if the best interests of the patient are to be served.

Inanition, anemia and not infrequently obstruction of a variable degree are manifested in many patients who harbor a carcinoma of the colon. Not infrequently the inflammatory reaction in the colon adjacent to the lesion is responsible for a mild febrile state with its concomitant clinical manifestations. Sometimes the localized infection incident to invasion fixation but more frequently the protective perforation of the lesion, with or without abscess formation, adds the problem of sepsis to be dealt with before any radical extirpative procedure may be employed.

It is of the greatest importance that the colon shall be cleansed as thoroughly as possible of all residue before instituting any type of colonic resection. In its accomplishment in the absence of obstruction several days may be employed to advantage preoperatively through the use of mild laxatives, enemas and a low residue diet. The incidence of obstruction of the colon is greater in the left colon than in the right side. Circumferential lesions of the cecum and ascending colon seldom are encountered, while they are common on the left side. It is of interest that circumferential lesions seldom produce obstruction through their own occlusion of the lumen of the colon. Instead, obstruction in the circumferential lesion is nearly always the result of impaction of a dehydrated fecal column against the lesion. The effectiveness of enemas has been demonstrated frequently in relieving this impaction-type of obstruction. Intestinal intubation and decompression through use of the Miller-Abbott tube have been demonstrated repeatedly as effective in relieving left-sided colonic obstruction. It should be carried in mind that a colonic obstruction may be dealt with with greater deliberation than obstruction of the small intestine. When decompression is not accomplished within a few days by nonsurgical means, the indications usually become clear for preliminary cecostomy or colostomy at some distance proximal to the lesion. I should like to repeat that obstruction must be relieved pre-

liminary to radical extirpation of an obstructing carcinoma.

Inanition and dehydration contribute much to the risk of surgical procedures on the colon, and certainly high caloric and vitamin fortification with restoration of body fluids preoperatively are urgently in order before resorting to any surgical procedure of magnitude. The preoperative transfusion of blood where anemia is prominently manifested materially enhances the patient's ability to withstand the operation of extensive resection of the colon for carcinoma.

The use of intraperitoneal vaccine preoperatively has been strongly advocated in certain surgical circles. Its value is a debatable question. It is entirely possible that the principles of immunity are brought to bear by such intraperitoneal vaccination. There seems to be no question but what a degree of immunity in vivo is established in many of the cases of carcinoma of the colon in which a protective perforation has occurred, as is evidenced by the relatively slight postoperative febrile reaction which is observed at times following a radical extirpation of such lesions in the presence of infection. On the other hand, as to whether the intraperitoneal introduction of vaccine forty-eight hours previous to colonic resection provides a degree of immunity, remains a matter clouded with considerable doubt. We may be certain that a preoperative introduction of vaccine into the peritoneal cavity does not provide occasion for undue liberties in the execution of the surgical procedures, nor does the use of vaccine compensate for technical errors.

SURGICAL PROCEDURES

An important question in the minds of many is that of the type of operation that shall be performed in operable carcinoma of the colon, particularly as to whether the operation shall be performed and completed in one stage or in two or more stages. Those who employ two or more stages in all cases stand on the principle that, through multiple stages, the maximum degree of safety is provided irrespective of the site of the lesion. There are some faults to be found in such a policy, but they are of insufficient moment to dwell upon them here. It may be stated, however, that malignant disease in certain situations in the colon and under certain circumstances may be removed successfully with restoration of intestinal continuity in one stage. Obstruction, protective perforation, marked anemia, generally poor condition of the patient, and senility, irrespective of the site that the lesion occupies in the colon and in every surgeon's hands, constitute for the most part definite indications for a multiple stage operation. It is worthy of emphasis that, whether the resection is performed as a primary or as a secondary operation, it should include as much of the mesentery not only adjacent to the segment of colon resected, but as much of that in which the lymphatics accompany the blood vessels, to insure the widest removal of any possibly involved lymph nodes.

Lesions of the Right Colon.—The right colon anatomically lends itself very readily to a one-stage

resection and restoration of intestinal continuity, and in patients in good condition in whom there is an operable mobile lesion of the cecum or ascending colon, the one-stage iliocolostomy and resection of the right half of the colon is preferred by many to the multiple-stage operation. For purposes of wide removal of possibly involved regional lymph nodes, resection of the cecum, ascending colon and the right third of the transverse colon is required in practically all cases of carcinoma of the cecum, the ascending colon and the hepatic flexure. In a number of instances where I have encountered a small lesion of the cecum or ascending colon without regional glandular involvement, I have had permanent cure of the cecal lesion following simple resection of the cecum with end-to-end anastomosis of terminal ileum and ascending colon, and cure of the lesion of the ascending colon through segmental resection and end-to-end anastomosis between the ascending and transverse colon.

The two-stage resection of the right colon is of two types. The usual procedure consists of an ilio transverse colostomy as the first stage, with resection of the right colon at the second stage. The procedure of Lahey embraces resection of the colon as the first stage, and restoration of intestinal continuity as the second stage.

Malignant Lesions of the Transverse Colon, Splenic Flexure and Descending Colon present problems in anastomotic procedures which have a distinct bearing on operative risk and mortality rate. They are usually most successfully operated upon by multiple or graded procedures, in the selection of which there is great variation in the sequence of the various steps as pertains, particularly to preliminary cecostomy or colostomy, resection and restoration of intestinal continuity as influenced by many factors. It may be stated that seldom, if ever, may one employ with any degree of safety a one-stage resection and simultaneous restoration of intestinal continuity for lesions in these situations.

Lesions of the Sigmoid likewise may seldom, if ever, be operated upon as a one-stage procedure wherein the resection is immediately followed with an end-to-end anastomosis in the absence of a previously made cecostomy or colostomy. It is in mobile lesions in this section of the colon that obstructive resection is employed most advantageously, with or without a previously made cecostomy or colostomy. On many occasions in my experience a cecostomy performed simultaneously with the obstructive type of resection for a carcinoma of the sigmoid has proven a useful safety vent during the postoperative period while clamp obstruction of the sigmoid was maintained. The temporary colostomy at the site of an obstructive resection of the sigmoid can be so fashioned that spontaneous closure occurs in approximately 50 per cent of the cases and thus obviates the necessity for subsequent surgical closure.

Lesions of the Rectosigmoid present many problems which are concerned primarily with the difficulties of maintaining or restoring intestinal continuity following resection, which must be weighed in each case against the advantages and disadvan-

tages of a permanent colostomy and abdomino-perineal resection in either one or two stages. The selection of the procedures that shall be used in lesions in this situation may be influenced by many factors and only through individualization of the patient may the purposes of the surgical procedures be best served.

In bringing this rather cursory discussion to a conclusion, I should like to repeat that many factors are concerned in the successful treatment of carcinoma of the intraperitoneal colon. Through early recognition of the disease, operability and curability of the disease have been somewhat enhanced during recent years, and through the employment of important preoperative measures and the judicious selection of surgical procedures operable, carcinoma in most segments of the colon can be removed within a reasonable and legitimate mortality rate.

727 West Seventh Street.

GOITER IN NORTHERN CALIFORNIA

A SURVEY OF ONE HUNDRED AND SEVENTY-FIVE THYROID OPERATIONS

By A. H. NEWTON, M. D.

Yreka

ENDEMIC goiter is highly prevalent in Northern California where the northern coast ranges join the Sierra Nevada ranges, extending from Del Norte throughout Siskiyou and Modoc counties. Of the one hundred and seventy-five goiter operations which I have performed, 95 per cent were for patients who were born or lived in this area most of their lives.

The average age incidence of those with nodular goiter at the time of operation was forty-five years. They presented moderate to severe heart damage at the time of operation, and most of them were rehabilitated following operation. The average age incidence at the time of operation of those with diffuse toxic goiter was thirty-five years. They gave a history of much shorter duration of the presence of goiter. Their chief symptoms were weight loss, extreme nervousness and cardiac. The cardiac symptoms in the diffuse, toxic group cleared more quickly following operation than the nodular group. Their more rapid rehabilitation following surgery was undoubtedly due to less permanent damage to the vital organs than the nodular group, as we know the toxic manifestations of the nodular type are more insidious, and degeneration of the myocardium is more advanced, while regeneration of heart reserve was more difficult to regain.

PREOPERATIVE PROCEDURES

A careful history was obtained in all cases and routine general physical examination made. Considerable importance was placed upon the history and personal observation of the patient in arriving at a diagnosis and mode of procedure. Laboratory work, such as blood counts, urinalysis, basal metabolism and electrocardiograph tracings of those with unchecked heart damage was done routinely. Iodin was administered internally to those with diffuse, toxic goiter, and in the case of nodular goiter where

the basal metabolism was plus 15 or above. Bedrest was instituted for a period of time preparatory to surgery, depending on the amount of heart damage and basal metabolic rate. Digitalis was administered to those with heart damage. This treatment was continued until the pulse rate was 100 or below with absolute rest. Little attention was paid to the presence of irregularity of rhythm. Those with high basal metabolic rates received continued treatment until the basal metabolism was perceptibly lowered before surgery was undertaken. A high caloric diet and fluids were administered freely during preoperative care.

OPERATIVE PROCEDURES

The preoperative preparation and careful handling of the patient were deemed of utmost importance in carrying them through a successful surgical procedure. The judgment of the operator as to the opportune time of operation was considered of utmost importance. Before the patient was deemed ready for operation, a tapwater enema was given each morning, and hypodermically, sterile water, for one or two mornings before surgery. On the morning of surgery, a basal anesthesia was administered rectally for the tapwater enema, and a small dose of morphin was administered hypodermically. The usual sedative was administered routinely as on previous days of hospitalization. The choice of anesthesia was usually between Gwathmy and avertin. The patient was transferred to the operating room in a semiconscious state, and placed upon the operating table in the operating position with the sandbag between the shoulders, the neck in moderate hyperextension. Following the usual skin preparation and draping of the patient, the skin at the site of operation was anesthetized with infiltration of 1 per cent novocain solution. The usual collar incision was made—a straight transverse incision 1 centimeter above the sternal notch and as short as possible. The skin and platysma were dissected to and above the cricoid cartilage. The deep cervical fascia and muscles were then infiltrated with 1 per cent novocain solution. The deep cervical fascia was divided longitudinally directly over the trachea and isthmus of the thyroid. The ribbon muscles separated and rarely divided, their division being done only for better exposure. At this stage of operation, nitrous oxid and oxygen gas were administered.

In the diffuse toxic goiter, sentinel hemostats were placed on the pole to be excised, one at the superior pole, one on the lateral capsule, dividing the lateral vein, and one on the inferior pole which included glandular tissue. The isthmus was then divided by inserting a Kocher dissector from below upwards and upon the trachea. Kelly hemostats were then clamped on both sides and the isthmus divided between them. The Kocher dissector was left in place to avoid injury to the trachea by the hemostats and dissecting knife. In this manner, the trachea was brought into view and maintained in view throughout the rest of the operation. The pole to be excised was then dissected away from the trachea with outward rotation. The operator's left index finger was put beneath the pole and against

the trachea, and hemostats were placed at right angles to the trachea, pointing away from the latter. In this manner, the trachea was kept in vision and dissection was carried outward upon the left index finger. Tissue was purposely left in the clasp of the lower sentinel hemostats in order to assure adequate blood supply to the posterior capsule and parathyroid glands from the branches of the inferior thyroid artery. The superior thyroid artery was isolated, and tied individually and never en masse. In this manner, the dissection of the gland was carried away from the trachea with outward rotation upon the left index finger of the operator and as much of the capsule would be preserved as the operator wished. The double and triple clamp method of hemostasis was used. The amount of glandular tissue left in each pole depended upon clinical history, physical and laboratory findings and judgment of the operator.

In nodular goiter, the operative technique varied with the situation of the nodules. All nodules were removed, and as much of normal gland tissue was left as possible.

Drainage was instituted only with the removal of large adenomata, which were substernal or where there was considerable dead space. In such cases drains were brought out through the lateral angles of the wound, and never centrally, and removed in twenty-four hours. During the past two years I have used fine silk for tying bleeders within the capsule of the thyroid. This has been most satisfactory, as I believe the use of extensive catgut in the tissue promotes the accumulation of serum, and many individuals have a tissue sensitivity to catgut. Silk prevents this. Triple 000 plain catgut is used, to approximate the ribbon muscles, deep cervical fascia and sometimes platysma; Michel clips are used in skin closure, part of the clips being removed in forty-eight hours and the remaining clips on the third postoperative day. Tying off bleeding points in subcutaneous tissue prevents accumulation of serum and blood clots beneath the skin flap, which is troublesome when it occurs, but is never serious. Following operation, codein and small doses of morphin were administered to control patient's pain and discomfort, and fluids given rectally and by mouth up to 4,000 cubic centimeters daily. The average period of hospitalization following surgery was five days.

RESULTS

Operative mortality in this series of cases: Three can be classified directly to operation. They had nodular goiter for many years and there was marked damage of the cardiovascular system as well as liver and kidney damage. Patient 1 died twenty-four hours following surgery, of circulatory and cardiac failure, aged 67. Patient 2 had an extremely large multicystic goiter of thirty years' duration. She was 67 at the time of operation, the goiter consisted of three large nodules, each measuring four inches in diameter, protruding beyond the chin. This woman in younger years was overweight and obese, being hypothyroid, and in the last year she lost one hundred pounds in weight, and developed anasarca from cardiac and kidney damage. Preoperatively

she was hospitalized over a period of three weeks, and the anasarca cleared, her heart compensated, and kidney function improved. She withstood the operation satisfactorily, but died thirty-six hours later of embolism. The third patient to meet operative death, aged 48, had a nodular goiter for twenty years which had become extremely toxic during the last few months prior to surgery. Basal metabolism was plus 30. Following treatment, it dropped to plus 18. Multiple substernal adenomata were removed at operation, the patient developed considerable tracheitis and edema of the larynx the day following the operation, and died four days later from bilateral pneumonia, type three.

POSTOPERATIVE PROCEDURES

Postoperative follow-up of the discussed series of patients since 1930: Three died from operation, one died one year following surgery of senile dementia, one died two years following surgery of pneumonia, one died four years following surgery of senile dementia. One died one year following surgery of malignant hypertension. Two died in the State Hospital for the Insane, two years following surgery. Four have died since operation from other causes. One hundred and twenty are leading fairly normal active lives, and the rest are unaccounted for.

COMMENT

I have had two patients with diabetes mellitus associated with hyperthyroidism. One was a young woman of twenty-five who had symptoms of hyperplasia. Laboratory examination established a diagnosis of associated diabetes mellitus. Subtotal thyroidectomy was done and several months thereafter, there appeared to be clinical improvement of the diabetic condition but during the past five years, she has remained under diabetic management. The other case was that of a man of forty-five who had a previous thyroid operation for diffuse toxic goiter. His diabetes cleared, but with the onset of hyperthyroid symptoms, his diabetic condition was reestablished. At the second operation, all visible thyroid tissue was removed. Following operation, it was necessary to administer thyroid extract. One year later, his diabetes cleared and has remained so during the past five years. The hypothyroid state subsided and the basal metabolism rate five years after second operation was normal.

The sex ratio of goiter in this series was 80 per cent females, and 20 per cent males.

Twenty per cent of the diffuse toxic goiter group had exophthalmus, and one case of exophthalmus was present in the toxic nodular group. The incidence of toxic nodular goiter was 55 per cent, non-toxic goiter, 5 per cent, diffuse toxic goiter, 40 per cent.

In no instance has there been a postoperative permanent vocal cord paralysis. In eight cases, total thyroidectomy was performed where angina and cardiac decompensation was severe. They are maintained at a minus 15 to minus 20 basal metabolic rate with one-fourth to one-half grain thyroid extract daily. One case, developed postoperative

parathyroid tetany and over a period of four years was given calcium and viosterol and parathyroid hormone.

SUMMARY

A survey of one hundred and seventy-five thyroidectomies is made. Operative mortality was 1.7 per cent. Careful preoperative preparation is important in keeping a reduced operative mortality. The technic of operation in dissecting the gland away from the trachea, conserving the blood supply to the posterior capsule, and the parathyroid, and use of silk, wound closure without drainage is discussed.

117 Miner Street.

THE INTERPRETATION OF LABORATORY EXAMINATIONS IN THE DIAGNOSIS OF INFECTIOUS DISEASES*

By CHESTER S. KEEFER, M.D.
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PART IV†

Sheep Cell Agglutination Test

One agglutination test which we have found to be of great assistance in diagnosis is the sheep cell agglutination test of Paul and Bunnell¹³ in the diagnosis of infectious mononucleosis or glandular fever. It is particularly helpful in the diagnosis of atypical cases and in distinguishing mononucleosis from leukemia. If one can exclude serum sickness, then a positive reaction in a titre of 1:32 or higher is significant and practically diagnostic of the condition. The following cases illustrate how helpful it may be in diagnosis.

A young man with fever, generalized lymphadenopathy, hepatomegaly, splenomegaly, jaundice, dermatitis, and lymphocytosis shows a positive sheep cell agglutination test in the blood. The clinical course was that of an infectious mononucleosis with a number of unusual features.

CASE 8.—A young man, 22 years of age, stated that he had been well until one week before admission to the hospital when he developed an acute respiratory infection, characterized by nasal obstruction, frontal headache, fever, weakness and nasal discharge. He remained in bed for four days and soon noticed that he had swollen glands in the neck, particularly in the anterior as well as the posterior cervical region. At that time his temperature was 100 degrees Fahrenheit. Within a short time his temperature had increased to 102 degrees Fahrenheit, and the lymph nodes had enlarged, becoming tender and painful. His past history was noncontributory.

Physical examination showed an acutely ill young man with temperature of 100 degrees Fahrenheit, pulse 95, respiratory rate 22, and blood pressure 106/50. The skin was flushed and he was perspiring. There was bilateral nasal obstruction, the nasopharynx was injected, and the lymphoid tissue was hypertrophied, especially the tonsils and the lymphoid tissue in the pharynx. The lymph nodes in the anterior-posterior cervical triangles were enlarged, firm, tender, movable, and discrete. Neck and breasts were normal; there were a few slightly enlarged lymph nodes in

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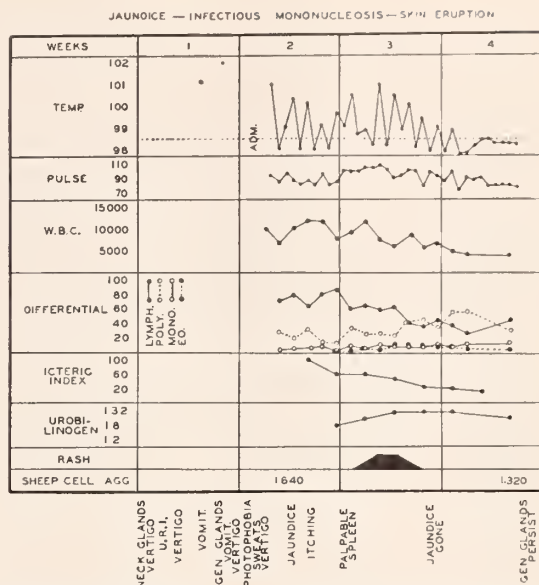


Fig. 5.—(Case 8) The clinical course of a patient with infectious mononucleosis, jaundice, and a skin eruption.

both axillae. The lungs were clear and resonant throughout. The heart rate was accelerated but the sounds were clear. The abdomen was moderately distended and there was some tenderness in the left upper quadrant. The spleen was palpable on deep inspiration; no other masses were felt. The rectum, genitalia and extremities were negative.

Laboratory examination showed a red blood cell count of 5,060,000, hemoglobin 100 per cent, and white blood cell count 9,800, with a differential count on admission showing 29 per cent polymorphonuclears, 66 per cent large lymphocytes, 4 per cent small lymphocytes, and 1 per cent eosinophiles. At this time it was thought that the patient probably had infectious mononucleosis, although two days later, when he became jaundiced, the question was raised whether or not the entire picture might be explained on the basis of infectious jaundice with a lymphocytosis.

The course of the illness with the laboratory examinations that settled this question are shown in Fig. 5. It was found that he had a sheep cell agglutination test, which was positive in a dilution of 1:640, and that this increased within several days until the titre was 1260.

Since it is known that a certain number of patients with infectious mononucleosis develop jaundice, it is well to employ this test in all individuals who have jaundice with a lymphocytic reaction. When this is done, it will be found that a large number of patients with infectious jaundice and lymphocytosis fail to show a positive sheep cell agglutination test. However, there is a small group of cases of infectious mononucleosis in which the jaundice is an outstanding feature and the lymph nodes in the periphery may not be markedly enlarged. This feature has been emphasized especially by DeVries in Holland,¹⁴ and the sheep cell agglutination test serves to differentiate between the cases of infectious jaundice and those of infectious mononucleosis with jaundice. Another group of cases of infectious mononucleosis in which the sheep cell agglutination test has been of great assistance, especially in differentiating this disease from acute leukemia, are those instances of the disease in which there is no enlargement of the peripheral lymph nodes, but only splenomegaly with lymphocytosis, such as is illustrated by the following.

A young man with fever, lymphocytosis, splenomegaly, and jaundice has a positive sheep cell agglu-

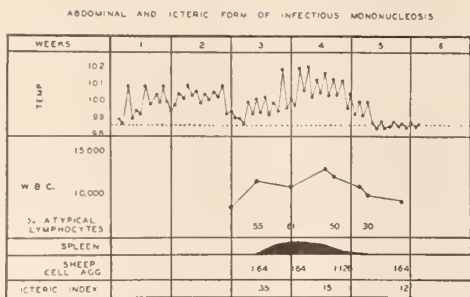


Fig. 6

Fig. 6.—(Case 9) Chart showing clinical course of patient with infectious mononucleosis without enlargement of peripheral lymph nodes.

Fig. 7.—(Case 10) Clinical course of patient with two attacks of pneumonia; the first resulting from Type I pneumococcus, the second from hemolytic streptococcus infection. The sputum contained both organisms during the second illness.

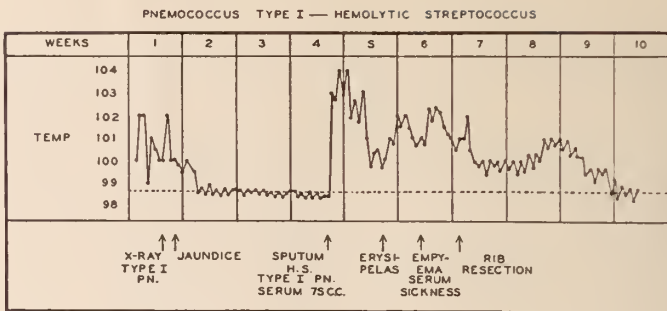


Fig. 7

tionation test without enlargement of the peripheral lymph nodes.

CASE 9.—A young physician had been acutely ill for a period of ten days with symptoms of headache, malaise, prostration and fever. There were no localizing symptoms or signs to account for his fever. On the tenth day of his illness it was found that he had a lymphocytosis and enlargement of his spleen. There were no palpable lymph nodes in the neck or axillae or groin. Since a number of the lymphocytes appeared to be abnormal, a sheep cell agglutination test was done and found to be positive in a tittle of 1:64.

The course of his illness is illustrated in Fig. 6. The patient made an uneventful recovery, the spleen decreased in size, and the blood returned to normal pattern.

Similar cases have been reported by Gordon,¹⁵ who has stressed the absence of enlargement of the peripheral lymph nodes. In any case, then, of jaundice with lymphocytosis, splenomegalia with leukocytosis, or glandular enlargement with lymphocytosis, sheep cell agglutination tests may settle the diagnosis and exclude more serious illnesses, such as leukemia.

SPUTUM EXAMINATION

Sputum examinations for various microorganisms are of the greatest importance in the diagnosis and accurate treatment of pneumonia due to the pneumococcus. Naturally, one should study the sputum for the presence of tubercle bacilli and the various mycotic infections when it is indicated; but the interpretation of the finding of various microorganisms in the sputum and their significance, in so far as a pulmonary infection is concerned, requires judgment and good technique. In the first place, it is absolutely essential that the specimen be obtained from the deep respiratory passages, since the contamination with saliva will often give erroneous results. If the specimen is satisfactory, then the relative number and the predominating organisms are the essential features. In any analysis of the finding of various organisms in the sputum, the following facts must be considered. (1) Between 85 and 90 per cent of all pneumonias are caused by the pneumococcus. (2) The other cases are accounted for by the hemolytic streptococcus, the staphylococcus, and the influenza or Friedlander bacillus. Of the pneumococcal infections, at least 85 per cent of the pneumonias are caused by six types: I, II, III, V, VII, and VIII. Therefore, the presence of large numbers of these organisms in the sputum is of greater significance than the presence of pneumococci of other types, since other types cause pneumonia infrequently in adults and are found more often in normal throats.

Conversely, Type I and II pneumococci are found infrequently in the throats of normal people unless they have been in contact with patients with pneumonia.

The careful examination of the sputum is of practical significance in the specific serum treatment of pneumonia and in the detection of cases of mixed infection. The following case stresses several of these points.

A young man has a Type I lobar pneumonia with jaundice but without bacteremia. He recovers completely but has a recurrence of his fever and signs of pneumonia seventeen days later. Sputum contained Type I pneumococci and hemolytic streptococci; treated with Type I antipneumococcus serum without results. Develops erysipelas and hemolytic streptococcus empyema.

CASE 10.—A man, 44 years of age, entered the hospital complaining of pain in the left chest and the right upper quadrant. The pain was worse on coughing. During the first three days while under observation he had high fever, abdominal pain and discomfort, nausea and vomiting without any definite physical signs to indicate a lobar pneumonia. At the end of the fifth day he coughed up some sputum which contained Type I pneumococci, and the x-ray of his chest showed an area of consolidation at the periphery of the left lung. He developed jaundice and recovered completely, the temperature returning to normal on the tenth day of his illness. He was discharged from the hospital quite well but returned five days after discharge, or seventeen days after his temperature had returned to normal from the attack of Type I lobar pneumonia.

On the second admission to the hospital he complained of pain in the left side of the chest, cough, nausea, vomiting, chills, fever and general malaise. Examination showed that he was acutely ill, his face was flushed, and he was shivering and complaining of being cold. There was evidence of a pneumonia at the left lower lobe, and x-ray confirmed this diagnosis. Laboratory examination showed a slight amount of albumin in the urine and a leukocyte count of 20,000. Blood cultures were negative. Sputum showed pneumococcus Type I and hemolytic streptococci. In view of the presence of Type I pneumococci in the sputum he was treated with 75 cubic centimeters of concentrated antipneumococcus serum without effect on his temperature or the signs in his lungs. Since this is unusual in typical cases of Type I pneumonia, it was thought that the infection was probably due to hemolytic streptococcus. This was soon confirmed by the development of both erysipelas and hemolytic streptococcal empyema. It was necessary to perform an open thoracotomy and drain the pleural cavity before complete recovery took place.

The course of his illness is illustrated in Fig. 7.

This patient presented several points in diagnosis which were difficult, especially during the second episode of fever. The interpretation of the findings

in the sputum in the second bout of illness was most difficult. While it was known that he had a Type I pneumonia a short time before and it seemed unlikely that he would have a second attack due to the same organism within seventeen days, such a possibility could not be excluded, since repeated attacks of Type I pneumonia have been observed with only a one-month interval between attacks. It was decided, therefore, to treat the patient with antipneumococcus serum. When he failed to respond in a characteristic way, a further examination of the sputum revealed not only Type I pneumococcus but hemolytic streptococci. That this organism was the cause of the second attack of pneumonia received support when he developed erysipelas and streptococcal empyema.

Therefore, in any patient who fails to respond to large doses of antipneumococcal serum, one should reexamine the sputum for other organisms, look for focal infections, and culture the blood.

COMPLEMENT FIXATION TESTS

In the diagnosis of gonococcal arthritis, the use of the gonococcal complement fixation test of the blood is helpful, especially in those cases in which the fluid is sterile and the local focus is either latent or obscure. In our experience¹⁶ the test is positive in 85 per cent of proved cases of gonococcal arthritis and, while occasional false positive reactions are encountered, the test is valuable in diagnosis when it is interpreted in the light of the clinical picture and especially in women with acute arthritis, in whom the gonococcal infection may be latent or in whom there is no positive history of infection.

EXAMINATION OF SYNOVIAL FLUID

In so far as infections are concerned, the examination of synovial fluid has its greatest field of usefulness in the diagnosis of tuberculosis, gonococcal and streptococcal infections of the joints, and osteomyelitis of a neighboring bone. In my own experience, the cases of gonococcal arthritis in which the examination of the synovial fluid is of the highest value are those where there is no obvious primary focus, yet gonococci are present in the fluid.¹⁷ Sometimes the finding of gonococci in such joints comes as a complete surprise.

When staphylococci are isolated from the synovial fluid, the chances are greatly in favor of the presence of an osteomyelitis which has spread to involve the joint. Indeed, an underlying osteomyelitis is so common in such cases that the question should always be raised whenever staphylococci are found in the joints. In every case of arthritis, the fluid should be examined for microorganisms.

THROAT CULTURES

It is now recognized that green, or nonhemolytic, streptococci, *B. influenzae* and staphylococci in throat cultures are of no significance. The finding of pneumococci may likewise be of no significance unless they are associated with signs of pneumonia, in which case they gain added significance if they belong to those types that frequently cause pneumonia. Organisms which are significant are hemolytic streptococci and diphtheria bacilli. In these there is usually a distinctive clinical picture to assist

in the interpretation of their significance. Before deciding whether an individual who is carrying these organisms in his throat is capable of spreading virulent organisms, the streptococci should be grouped for Group A and the diphtheria bacilli tested for virulence in guinea pigs. There is one throat infection which is due to a virus and from which one does not obtain any specific microorganism; this is herpetic pharyngitis. This diagnosis can be made from the appearance of the throat, the clinical course, and the isolation of the virus by inoculation of material into the cornea of a rabbit and by dark field examination.

Organisms of significance in infections of the middle ear, mastoid, and paranasal sinuses are staphylococcus aureus, hemolytic streptococci, pneumococci, and influenza bacilli. The others are probably of little etiologic significance.

URINE EXAMINATIONS

Bacteriological cultures of the urine both establish the etiologic diagnosis of urinary tract infections and, when they are done in a quantitative manner, provide information concerning the intensity and severity of the infection. Occasionally the presence of bacilluria without pyuria allows one to make a diagnosis of renal tract infection, which can not be established in any other way. This is true in some cases of staphylococcus infection of the kidney. With the introduction of sulfanilamide as a chemotherapeutic agent, it is more important than ever that cultures be made, since some organisms are resistant to the drug while others are susceptible.

STOOL EXAMINATIONS

There is no bacteriologic examination that offers greater difficulties in interpretation than the examination of the stools. The organisms of importance are those belonging to the enteric and dysentery group. In the case of the dysenteries, the clinical features of the illness, together with finding the organism in the stools and a positive agglutination reaction in the blood, suffice to make the diagnosis. Amoss and Poston¹⁸ have found *B. melitensis* in the stools of patients with that infection and, of course, stool examinations are important in the diagnosis of enteric infections without bacteremia and before agglutination reactions are positive. This is especially true in the salmonella group of organisms, particularly in those due to *B. suis* and *B. typhimurium*.

COMMENT

In the preceding discussion I have attempted to illustrate some of the problems that arise in the interpretation of laboratory examinations in the diagnosis of infectious diseases. You have undoubtedly realized that in many cases the correct interpretation of these examinations is of the highest importance in both diagnosis and prognosis, and the maximum amount of information can be obtained only when the laboratory examinations are interpreted in the light of the clinical picture and the course of the disease.

SUMMARY AND CONCLUSIONS

The significance of various laboratory examinations in the diagnosis of infectious diseases has been

discussed and various common problems have been illustrated with reports of cases.

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PSYCHOSIS DUE TO SULPHANILAMIDE

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MENTAL disturbances are among the toxic effects produced by sulphanilamide. The mental symptoms may be mild, such as emotional depression or emotional elation, or they may be more severe and constitute a true toxic psychosis.

The mental symptoms are of an episodic character, and of short duration, with recovery occurring when the drug is withdrawn. Because of the nature of the illness, it is therefore uncommon for patients suffering from mental disorders caused by sulphanilamide to be committed to state hospitals.

The following is the report of a case of toxic psychosis due to sulphanilamide and caused by its prolonged use.

REPORT OF CASE

A student, twenty-two years of age, was admitted to the Napa State Hospital on April 4, 1940. He had been violent, resistive and overactive, and was in restraint at the time of admission. When seen on the ward shortly thereafter, he was confused, disoriented, resistive, overactive, and exhibited bizarre behavior.

The statements appearing on the commitment papers described his behavior as quite violent, talking and acting in an irrational manner. He was reported to have imagined people were against him and they were trying to harm him. He had lost interest and become preoccupied with delusions and hallucinations.

Examination.—The patient was a slender white male; he was well developed, but only fairly well nourished. Weight, 135 pounds; height, 70½ inches. Temperature, pulse and respiratory rate were normal. The systolic blood pressure was 138 mm. of mercury and diastolic, 80. The heart, lungs, abdomen, and extremities were not remarkable. There was no cyanosis of the skin. The eyes were negative. There was a profuse purulent urethral discharge. Smears showed many Gram-negative intracellular and extracellular diplococci.

The neurological examination was not remarkable.

The urine was loaded with pus cells. The blood Wassermann test was negative. The white blood cell count was 12,500.

Course of Illness.—The patient was isolated and treated for gonorrheal urethritis. His mental condition remained confused, and he was disoriented. He was alternately mute and overtalkative; at times he was restless and physically overactive, when it became difficult to keep him in bed,

and at other times he assumed fixed bizarre positions. He reacted to delusions and hallucinations with a tendency toward violence. His condition remained unchanged until April 9, 1940 (five days after admission), when the mental confusion cleared and he became aware of his surroundings, but remained somewhat hazy. He was fearful and suspicious of other patients about him. Two days later he was entirely clear. He remained quiet and pleasant, and readily made friends with patients and employees. As his physical condition improved, he had the liberty of the hospital grounds. He went home four weeks after admission. He had complete insight into his mental illness.

A medical history could not be obtained upon admission due to mental confusion. After recovery from his mental symptoms he gave the following history:

On or about December 11, 1939, he started treatment for an acute gonorrheal urethritis. He took sulphanilamide in the following dosage: 80 grains daily for two days, 60 grains daily for two days, and 40 grains daily for the following forty-one days. During the last few days his friends noticed a change in personality; he was mildly elated, overactive, talkative, and argumentative. The symptoms disappeared when the sulphanilamide was discontinued for one week. Sulphanilamide, 40 grains daily, was resumed and continued for two weeks. After a rest period of one week sulphanilamide was again instituted because the urethral discharge had again become profuse. The dosage of sulphanilamide was 80 grains daily for two days, 60 grains daily for two days, and 40 grains daily for the following twenty-seven days. About eight days before the final dosage the patient became overactive, talkative, and argumentative. He gradually became more restless and unable to sleep. On March 25, 1940, he developed mild persecutory delusions and auditory hallucinations, and was fearful and apprehensive. On March 28, 1940, he entered the County Psychopathic Hospital. He had no recollection of what happened until April 9, 1940. The period of mental disturbance lasted eleven days.

It is estimated that the patient received 3,840 grains of sulphanilamide in 101 days.

On subsequent interviews the patient was able to recall some of his psychotic experiences, but they were never clear, and seemed dream-like. He remembered auditory hallucinations accusing him of misconduct; he imagined people were against him and trying to harm him. He was apprehensive and fearful. He felt a desire to protect himself against his imaginary persecutors, and knew he reacted with violence.

The patient's intellectual capacity was average for his station in life. He had never before had a mental illness.

COMMENT

Brown, Thornton and Wilson studied the toxicity of sulphanilamide in one hundred patients, observing in five, mental depression and in two, delirium caused by sulphanilamide. Levy found that when given large initial doses of the drug, a few patients suffered depression.

Bannick believed that the toxic manifestations were on a basis of sensitivity and idiosyncrasy. Garvin noted mental symptoms after long administration of sulphanilamide or following the administration of smaller doses. He cites the case of a young girl, who ten to fifteen minutes after receiving 1.3 grams of sulphanilamide, became so irrational, disoriented and excited as to require full restraint. This occurred after each dose of the drug and usually lasted for two or three hours. Fisher reports two cases of encephalomyelitis after use of small doses of sulphanilamide, and believes that the patients were more than ordinarily susceptible to the drug.

Hogan and McNamara report a case in which the toxic symptoms occurred after the drug had been discontinued. In Danziger's case mental symp-

toms developed five days after the drug had been discontinued.

Headaches, dizziness and lethargy may be premonitory symptoms, but Ottenburg does not believe that they are precursors to the more serious toxic symptoms; they may, however, go on to a more serious mental state.

The mental symptoms are nonspecific and, as in other toxic psychosis, are dependent upon the personality of the person. In most cases reported mental confusion and disorientation were present, some patients were retarded, depressed and negativistic, others exhibited bizarre behavior, and still others were maniacal. Delusions and hallucinations were present and usually of a persecutory and fear-some nature.

IN CONCLUSION

A case of toxic psychosis, following prolonged use of sulphanilamide, is reported. Premonitory symptoms were elation and excitement, and after withdrawal of the drug a confused delirious excitement occurred, with delusions of persecution, hallucinations and fear. Recovery occurred upon withdrawal of the drug.

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INJURIES TO NERVES DURING ANESTHESIA*

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NERVE injuries to the unconscious patient are not frequent, but are extremely disconcerting and usually result from the ignorance or carelessness of the anesthetist and staff in placing the patient on the operating table.

Probably the most common nerve to be injured is the ulnar, because of its exposed position at both the wrist and the elbow. At the wrist the nerve may be injured in two ways. A leather cuff restraint may be cinched too tightly about the wrist, compressing the nerve between the cuff and the bone. Again, in the lateral or kidney position, when the arms are flexed and the hands are restrained near the patient's face, pads must be inserted between the wrists and the metal anesthetist's screen to prevent pressure on the nerve between the screen and the bone. If the operating table is too narrow and the table pad thin, the elbow may rest on the metal edge of the table, with resultant paralysis. Even with wider tables and an adequate mattress, pressure may still be exerted if the wrists are restrained in leather cuffs clamped on a bar at the edge of the table, *unless* extra padding is placed under the elbow; a folded bath towel slipped between the mattress and the table being sufficient. A better arm restraint is made by folding a sheet in thirds, and placing it on the operating table so that, when the patient lies on it, the sheet reaches from the axilla to the finger tips and forms two "sleeves" into which the arms may be slipped; by pulling up the free ends of the sheet on either side

of the table, the arms are drawn snugly to the patient's sides. When the patient and table are disproportionate in size, extra padding is needed even with this restraint. If the patient is small enough, or the table is wide enough, so that the elbows are on the mattress, no additional cushioning is necessary.

In like manner, in the face-down or prone position, the musculospiral nerve in the upper arm may receive insult at the edge of the table if additional padding is not supplied.

It should go without saying that, in the lithotomy position, the legs should be placed outside the standards that hold the stirrups; but there have been cases in which injury has been done to the peroneal nerve because the leg was inside the standard, thereby compressing the nerve between the metal and the head of the fibula. In the lateral position, when the lower knee is flexed, there should be extra padding under it, to be sure that there is no compression of the peroneal nerve at the edge of the table.

INJURIES RESULTING FROM OTHER POSITIONS

A much more serious injury is one in which the brachial plexus, as a whole or in part, may be involved. Damage may be caused in two ways. First, from direct pressure on the plexus from the shoulder brace alone. A good shoulder brace should be well padded, broad and straight, or with only a slight curve rising at right angles from the table. It should slide on a bar to accommodate the differing shoulder widths of individual patients, and should be placed so that when the patient is in the Trendelenburg position the weight is borne by the top of the shoulder girdle just above the acromial process. With an unpadded brace having too great a curve, and placed too close to the neck, the weight is borne by the unpadded tip which is pressing into the plexus in the supraclavicular fossa. This, of course, is an extreme picture, but varying degrees of maladjustment will cause more or less damage. The second form of injury is caused by placing the plexus under tension and stretching the nerves. Though an operation may start in the usual supine position with the arms restrained in the leather cuffs with elbow pads in place, it may later develop that the Trendelenburg position is required. The shoulder braces are hastily put on, but are not snugly adjusted, so that the patient literally hangs by the wrists during the rest of the operation. This exerts a tremendous pull on the nerves of the plexus, with the greatest strain being placed on the upper roots. The nerves of the plexus are also put under strain at any time when the elbow is elevated above the plane of the shoulder, and this places more strain on the lower division of the plexus. In severe tension of either type, the entire plexus may be affected. One situation in which this latter type of injury to the brachial plexus may arise is when all usual care has been taken in placing the elbow pad and shoulder brace, but it becomes necessary to give the patient intravenous solutions. The vein of the arm is selected and the arm is placed on a board or table at right angles to the operating table. If the arm is pushed farther and farther cephalad to allow room for the surgeon and assist-

* Read before the joint session of the Sections on Anesthesiology and Obstetrics and Gynecology at the sixty-ninth annual session of the California Medical Association, Coronado, May 6-9, 1940.

ants, the elbow is elevated past the plane of the shoulder, the plexus is put on a stretch, and the time needed to allow the solution to run in is sufficient to result in paralysis. Other ways in which the same injury is obtained may be mentioned; for example, the arm may be placed on a board or table at right angles to the operating table for operation on the hand or arm or in the axilla, or be fastened to the anesthetist's screen or to a standard placed beside the operating table. In any of these situations all is well as long as the elbow stays below the plane of the shoulder; but if the armboard, screen, or standard is gradually pushed toward the head until the elbow is above the shoulder, the damage becomes greater and greater, depending on the length of time the position is maintained. In giving a "whiff of gas" for a minor procedure a patient may be allowed to go to sleep with his arms above his head; the "whiff" increases in length and he awakens with numbness in his hands. In the face-down or prone position, the arms should be restrained at the patient's sides; if they are brought up around the patient's head, the elbows are above the shoulders and the nerves of the brachial plexus are placed on tension.

The arms may be crossed over the chest and held by turning the hospital gown up over them and tucking the ends under the shoulders. This method is satisfactory when the patient is in the lithotomy position or at other times when the elbows are not in the surgeon's way. We know of one such instance, however, in which the arms were restrained thus in a gall-bladder operation. The arms, being in the way, were gradually pushed laterally and upward until the elbows were above the shoulder plane, and the patient awakened with a nearly complete bilateral palsy of the brachial plexus which, at the end of a year, still showed some residual paralysis in the distribution of one median nerve.

SUMMARY

With care and attention to a few anatomical details, nerve injuries to the unconscious patient are easily prevented. Fortunately, the paralysis is usually transient; but, in severe injuries, residual paralyses have persisted for more than a year.

University of California Hospital.

CONDITIONED REFLEX THERAPY OF ALCOHOLIC ADDICTION: SPECIFICITY OF CONDITIONING AGAINST CHRONIC ALCOHOLISM*

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AND

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EVERY physician is familiar with the extent of the problem of chronic alcoholism, the suffering it causes its victims and their families, and the difficulties of treatment. Even psychotherapy, under the best possible conditions, can report only 15 per cent total abstinence for a period of eighteen months

or longer.¹ Medicine has so often failed the chronic alcoholic in his search for help that many have turned to religion, the understanding and encouragement of ex-alcoholics² or friends, or various alcoholic sanatoria, and have been rewarded with a cure.

About five years ago one of us (W. L. V.), became associated with one of these sanatoria as its medical director. The treatment inaugurated, using the principles of the conditioned reflex, resulted in a confirmed total abstinence, for four years or longer, of 64.3 per cent in 538 patients so treated.³

One of us (F. L.), a psychiatrist, was so favorably impressed by the success of the conditioned reflex treatment, in cases previously treated unsuccessfully by the usual hospitalization and psychotherapy, that he joined forces in trying to strengthen the treatment with a psychologic approach designed to meet the special needs of the alcoholic.

METHOD OF TREATMENT

The details of this new method of treatment have been reported elsewhere.³ In short, it consists of establishing a conditioned reflex against alcohol with from four to seven treatment seances over a period of three to seven days. The patient is given liquor to drink (conditioned stimulus), and shortly after is made acutely ill by means of hypodermic injection of a nauseant drug (the unconditioned stimulus). The ultimate establishment of the conditioned reflex in most patients results in a strong aversion to the sight, smell and taste of alcohol.

RESULTS

As already stated, a series of 538 patients treated by the conditioning process gave a confirmed total abstinence rate for four years or longer of 64.3 per cent. Although many factors, including suggestion, operated to produce this gratifying result, the following two cases are reported to show the specificity of the aversion produced by the conditioned reflex itself.

REPORT OF CASES

CASE 1.—A 33-year-old accountant, white, married, was admitted to the Shadel Sanitarium for the first time on June 7, 1939, for chronic alcoholism. He was given two conditioning seances for whiskey and wine, and felt so sure of the results that he left on the third day of hospitalization, against advice, not having been conditioned against beer.

He remained completely abstinent for about six months, being unable to even look at a whiskey advertisement without aversion. About two months before readmission on February 9, 1940, he became disgusted because of marital and financial troubles and attempted to drink wine and whiskey without success. Finally, in desperation, he began drinking beer. After two months of beer-drinking, he returned voluntarily for conditioning against beer. The aversion against wine and whiskey still persisted to such an extent that it was unnecessary to reinforce these aversions. A few treatments directed against beer reestablished total abstinence which has persisted to date.

~ ~ ~

CASE 2.—A 41-year-old clerk, white, married, was admitted to Shadel Sanitarium for the first time in 1938 for the treatment of chronic alcoholism. He had never drunk anything but whiskey and beer and was therefore conditioned only against these.

He remained totally abstinent for a year and then in a fit of depression attempted to drink both whiskey and beer

* From the Shadel Sanitarium for the treatment of chronic alcoholism.

without success. About six months later and three months before his second admission to the Sanitarium, he successfully drank some wine which had never appealed to him before and against which he had never been conditioned. He began drinking again, limiting himself to wine.

At the time of his second admission, on April 2, 1940, he was in such a depressed state that a diagnosis was made of a depressive psychosis. He was conditioned against wine only, as his original aversion to beer and whiskey still persisted.

Two months after his last treatment he was committed to a state hospital still abstinent in spite of several attempts to drink because of his depressed condition.

COMMENT

These two case histories illustrate the specific effect of the conditioning treatment against alcoholism. Both patients made unsuccessful attempts to drink the alcoholic beverages against which they were conditioned, but succeeded with drinks for which aversion had not been established.

The last case history brings up a problem which has probably seldom arisen before. Are there some psychopathic patients who need alcohol to avoid the complete breakdown that total abstinence might precipitate? In another case abstinence was demanded by a wife on the threat of a divorce. This resulted in a depressive psychosis and suggests that occasionally alcohol protects a patient against a more serious mental disorder. This is probably a rare situation but should be considered possible.

It is not our intention to convey the idea that this treatment is as specifically effective in all cases as in the two reported, for patients obviously differ in the ease with which aversions can be produced. In the first case, specific aversion was still present eight months after treatment, and in the second case two years after treatment. In other patients, fortunately a minority, the aversion may last only a few days. The reason for this difference needs further investigation.

SUMMARY

1. The conditioned reflex treatment of chronic alcoholism has produced a confirmed total abstinence rate for four years or longer of 64.3 per cent in 538 cases so treated.

2. In most patients, the established aversion is highly specific and may last for two years or longer.

3. Two cases are reported in which the patients were unsuccessful in their attempts to drink the alcoholic beverages against which they had been conditioned. They succeeded, however, in drinking alcoholic beverages for which they had not been conditioned. Subsequent treatment directed against these beverages produced total abstinence.

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PHYSICIANS IN GOVERNMENTAL SERVICES: A PRELIMINARY REPORT ON SOME CALIFORNIA CONDITIONS*

AT the last meeting of the House of Delegates a resolution was passed asking for the appointment of a committee to study conditions of compensation, hours, and patient-load of doctors of medicine employed by city, county, state, and federal government. This committee was appointed and began its work. Its chairman felt that he had been assigned a rather innocuous task that might require some work, but would be devoid of result. We did not quite know how to go about our task or to get the desired information, since we could not obtain such information from every governmental organization that employed physicians. And so we began to write letters to Veterans' Facilities, located at different points, such as San Francisco, Livermore, Sawtelle, and the San Fernando Veterans' Home. We figured that these would act as a pattern for all Government institutions throughout the country. We felt that one such institution, such as the Agnews State Hospital for the Insane, would serve as a pattern for the rest of the state institutions. Realizing that we could not take every county in the state, we limited ourselves to Alameda, Santa Clara, Los Angeles, San Diego, Orange, and San Francisco counties. For health departments we took the three larger counties—Los Angeles, San Francisco, and Alameda. After a few months the correspondence became so voluminous, and the figures so complicated, that the Central Office was asked to furnish us a statistician.

This statistician segregated figures as far as possible, and three tables have been placed in the files of the central office of the California Medical Association for future reference and study.†

Having nothing by which to guide us, we segregated different positions and institutions under time spent, salary per year, salary per month, and salary per hour. Some of these salaries carry maintenance, some of them are full-time without maintenance, and some of them are part time. Since we had no basis or experience upon which to figure, an arbitrary number of hours was assigned to all positions. We used the industrial figure of forty-four hours per week, and one hundred and seventy-six hours per month. Table I, column 5, is figured for all full-time positions on this basis. Since salary schedules may range more than \$1,000 for different positions, and since they also have a very wide range for the same type of

* This is a report submitted by a special committee appointed in response to a resolution presented at the annual session of the California Medical Association held at Del Monte, May 1-4, 1939; the committee consisting of William C. Voorsanger, Chairman, R. Stanley Kneeshaw, and L. A. Alesen. Report was submitted to the California Medical Association House of Delegates, at Coronado, May 6-9, 1940. For references, see CALIFORNIA AND WESTERN MEDICINE: June, 1939, on page 436 (item (b)); June, 1940, on page 280 (item: Report of the Committee on Governmental Medical Employees.)

† The captions of the three tables are as follows: Table I, "Compensation to Physicians in Various Government Positions in California, 1940"; Table II (A), "Full-Time Positions Held by Doctors of Medicine by Salary Groups for Government Positions in California, 1940"; Table II (B), "Part-Time Positions Held by Doctors of Medicine by Salary Groups for Government Positions in California, 1940."

position in various communities, Table II (A) was made. This shows, by intervals of \$1,000, the various salaries which may be earned by doctors performing duties under stated titles and by the Government unit. This table, however, does not attempt to show how many doctors are employed in the stated positions. Table II (B) shows the same data as Table II (A), but all part-time positions are shown.

A close study of figures, for instance those referring to Federal institutions, would show a range of \$3.03 to \$1.48 per hour for full-time employees. Some part-time employees, such as special fields, would appear on the face of things to be paid fairly well; for instance, an eye, ear, nose, and throat specialist gets \$13 a day, and a urologist \$50 a day. These specialists work only twice a month for the Government, so the salary of the eye specialist is \$26 and the urologist, \$100 a month. How much work is done for this compensation is not specified. In the state institutions, salaries range from a top of \$5,040 per annum for the superintendent, down to the junior intern, who receives nothing. If we break down this salary to a forty-four-hour week, we shall find that the range is from \$2.39 an hour down to 29 cents an hour for an intern. A junior physician, figuring forty-four hours per week, would receive from 57 to 80 cents per hour. We find a little better spacing in analyzing our county institutions, where there are positions paying two to three, and ten to twelve thousand dollars a year, such as full-time health director of a large community, or full-time director of a large hospital. Most of the salaries after the top, however, take a nose dive, and if those in our counties are broken down into payment per hour, they again range from \$5.74 down to a low of 29 cents. Some positions, such as a full-time roentgenologist, pay from \$2.27 to \$2.56 per hour. A clinic physician doing full-time work receives from \$1.42 to \$1.70 an hour. An epidemiologist, full-time, receives from \$1.99 to \$2.27 an hour. Full-time positions in most of the county tuberculosis hospitals range from \$2.50 to \$1.70 per hour. If we forget the compensation per hour and turn to Table II (A), we shall see that positions held by directors of medicine in the year 1940 range from \$10,000 down to \$500 a year. There were no salaries in the eight or nine thousand brackets. There were a few in the seven to five thousand bracket, and then again the decline was rather precipitous. Table II (B) will give you some detail about part-time positions held by doctors of medicine in California in the year 1940, and we find a few of these pay from six to four thousand, but the majority are from three thousand to five hundred.

This report is not complete by any means. We feel that sufficient information has been gained, and these tables from various counties and the state and federal governments demonstrate clearly that, barring a few positions at the top, doctors are underpaid and overworked. The large majority of physicians doing full-time work are not receiving the pay per hour of first-class mechanics in industry. Your committee feels very strongly, first, that

should a more complete analysis be required for study, a detailed questionnaire must be sent out. Second, it recommends that further study of the whole question of compensation to doctors of medicine in government employ be continued, with the understanding that, if it is continued and proper information is to be obtained, a statistician must be employed, whose duty it will be to go personally to these various institutions and interview types of doctors in various forms of employment. Only in this way shall we be able to get accurate and complete information regarding this whole matter of medical compensation. Your committee also recommends that due publicity be given to the fact that its investigation has proved definitely the inadequacy of compensation paid to doctors in full-time employment, comparing this compensation with full-time employment in industry. (It can be demonstrated that roadmasters in federal service, with less responsibility, draw equal pay with doctors.) We recommend, also, that if this investigation is continued, special study be given to the patient-load placed upon doctors in federal, state, and county hospitals, the average at present being about fifty patients per day per doctor. Your committee feels strongly that, unless proper efforts are made to better the conditions under which full-time medical employees work, a deterioration, both in the character of work and the health of the employee, is bound to result.*

CLINICAL NOTES AND CASE REPORTS

PSEUDOCYESIS

By ALBERT T. GOLDBERG, M. D.

AND

MILTON M. SCHATZ, M. D.

Fresno

SPURIOUS pregnancy has been recognized since the earliest times. The Hippocratic volumes showed at least twelve cases around 300 B. C. The case of Mary Tudor, Queen of England, is reported as one of imaginary pregnancy.

Such outstanding men as Madden, Montgomery, and Simpson gave considerable attention to this condition in the middle of the nineteenth century.

The condition is mentioned, but in passing, in our textbooks on obstetrics, and references in the medical literature, are scant.

A great number of terms are given this state: Pseudocyesis, spurious pregnancy, phantom pregnancy, imaginary pregnancy, hysterical pregnancy, and simulated pregnancy. Although the term "feigned pregnancy" is frequently used synonymously in reference to this condition, it really is a misnomer. "Feigned pregnancy" should denote

* The committee gives its especial thanks to Miss Eleanor Hanna, statistician, who compiled these figures, and to Dr. Berthel Henning, who supplied the chairman of this committee with valuable information regarding Federal institutions.

only such a condition in which malingering or intentional deception is attempted.¹

Pseudocyesis may be present in young women as well as those approaching the menopause. It is seen in women who have a decided fear of pregnancy, either because of illicit intercourse or because of the dread of supposed dangers associated with pregnancy and labor. Occasionally women who are extremely desirous of becoming pregnant reveal these manifestations. Then there is that group of women who imagine themselves pregnant because of the presence of functional or pathologic disturbances, attended by symptoms which simulate the signs and symptoms of pregnancy.

The factor of an endocrine imbalance accounts for much of this picture, and is the reason why this condition is most common in women approaching the climacteric. Misleading symptoms of pregnancy may be present at this time because of the natural tendency toward scanty menses and increased deposition of fat, especially about the abdomen and breasts.

Other pathologic states which may account for some of the findings are: carcinoma of the uterus, uterine fibroids, ovarian cysts, ascites, bowel distention, hydatidiform mole, etc.

Such nonpathologic states as spasm of the diaphragm, with relaxation of abdominal muscles, may cause an impression of abdominal enlargement, as may also fat deposits. The sensation of fetal movement (quickening) may be due to movement of gas in the intestines or contraction of abdominal muscles.

Practically all of the symptoms, and occasionally some of the presumptive signs of pregnancy, may be manifest: Amenorrhea, nausea and vomiting, gain in weight, pica, quickening and simulated labor pains. Quickening is a very common symptom, and many patients complain that it is quite obvious to onlookers. That a colostrum-like material may be expressed from the breast is evident in the cases reported by Jacobs.² Rarely pigmentation about the nipples may occur.³ The presence of striae on the wall of the enlarging abdomen is quite common.

The true nature of the condition is readily revealed when, upon examination, the fetal heart tones and funic souffle are not heard; although a rapid transmitted maternal pulse may resemble the fetal heart tone. A small uterus, the absence of a positive Hegar's or Chadwick's sign, is quite convincing. In doubtful cases the x-ray or the Ascheim-Zondek test, or one of its modifications, may be resorted to.

Pseudocyesis is most commonly found in the neurotic and less intelligent types of individuals, especially those suffering from mental and emotional changes. However, occasionally it may fool even an intelligent woman who has had previous pregnancies.

Many women will not be convinced that no true pregnancy exists, and they may continue with this disillusion long after the term of pregnancy has passed. Montgomery cites a case of nine years' duration, and Dupuytren one of fourteen years.⁴

REPORT OF CASE

Mrs. A. B. C., age 24. Married five weeks. Presented herself for examination on March 9, 1939, stating that she missed her menstrual period due on March 1, 1939. Her menses previously were regular, occurring every twenty-eight days, duration four days. Pelvic examination at this time revealed normal findings, and the patient was instructed to return in one month, as the present examination revealed no sign of pregnancy. She was certain that she was pregnant, and we explained that it was too early (eight days after missed period) to determine definitely the presence of pregnancy at that time.

One month later the patient returned. No menses had occurred in the interim. She complained of "morning nausea" occurring quite frequently, and a sensation of fullness in her breasts. Complete examination at this time revealed a rather obese female weighing 158 pounds. (Impression of glandular—hypothyroid—type. Ideal weight should have been 121 pounds.) The uterus was small, firm, of normal color, and retroverted to a second degree position. Blood Wassermann was negative.

The patient was informed that she was not pregnant, but she left the office doubting this diagnosis.

On November 4, 1939, the patient returned to the office, complaining of severe lower abdominal pains. These were intermittent in character. She stated that she was definitely pregnant and was having premature labor pains. The date of expectancy, calculated from date of the last period (March 1, 1939), would have been December 8, 1939, or one month hence. She had gradually gained in weight until she reached 185¼ pounds or a gain of 27¼ pounds. She complained considerably of fetal movements, stating that they were so annoying that they kept her awake all the previous night. No menstruation had occurred since the first examination.

Examination revealed the abdomen to be enlarged to the level of the umbilicus. The abdomen was not firm, but of a soft obese type. Pelvic examination was entirely normal with no evidence of gestation. An x-ray film taken of the pelvis and abdomen revealed no evidence of fetal skeletal structures.

Pacific Southwest Building.

SCABIES: ITS TREATMENT WITH A SPECIAL SULPHUR SOAP*

By HAROLD P. TOMPKINS, M. D.
Santa Barbara

THERE are many methods of treating scabies. The majority of them are efficacious when properly applied. Most of these methods make use of sulphur, which proves specific against the parasites and ova.

The chief therapeutic problem appears to be the proper application of any acceptable compound, not the compound itself. Sulphur ointments are usually disagreeable to the patient when applied to the body from the neck down. This fact alone tends to discourage thorough application of the ointment. Sulphur dermatitis following the prescribed ointment routine is not uncommon. However, this usually responds readily to treatment and proves to be little more than an unpleasant side effect.

* Quoted from (1).

* The sulphur soap used was prepared by Chemical Industries of California, under the name "Thiofoam."

¹ Paddock, Richard: Spurious Pregnancy, *Am. J. Obst. & Gynec.*, 16:845-854 (Dec.), 1928.

² Jacobs, J. B.: Pseudocyesis, *Virginia M. Monthly*, 57: 178-180 (June), 1930.

³ Erickson, C. W., and Hashinger, E. H.: Case of Pseudocyesis Associated With Endocrine Imbalance, *J. Kansas M. Soc.*, 35:395-397 (Oct.), 1934.

Dr. Roger A. Nolan, U. S. Navy, advised the use of sulphur incorporated in soft soap. This he found to be a highly satisfactory method of treatment and prophylaxis of scabies. In the past 18 months over 400 cases of scabies have been treated in the Dermatological Clinic of the Ventura County Hospital with a compound containing 18 per cent precipitated sulphur in *sapo mollis*, U. S. P.

The routine is a bath with soap and warm water, followed by a complete lathering of the body with the sulphur soap, which is allowed to dry. This is repeated for three nights. The usual change of clothing and bedding before and after treatment is important.

Not one case of sulphur dermatitis has resulted and the percentage of cures with the above routine treatment is very high for the type of patient seen. While the sulphur content of the soap is 18 per cent, one ounce of it is sufficient for three applications over the adult body. This means approximately 1.8 grams of sulphur per application. The low sulphur content makes it unnecessary to decrease the concentration for children and infants.

This preparation is easy to apply and does not damage clothing. It may be used in other dermatological conditions where sulphur ointment is indicated over large areas, or as a prophylactic against parasites where sulphur is indicated.

CONCLUSIONS

1. Sulphur (18 per cent) incorporated in *sapo mollis* is more desirable than sulphur ointments in the treatment of scabies, because the ease of application and lack of unpleasantness facilitates its proper use.

2. With the use of this preparation there is an absence or decrease in incidence of sulphur dermatitis secondary to treatment.

3. This preparation is useful where sulphur is indicated over large body areas, and as prophylaxis against certain parasites.

1520 Chapala Street.

HIPPOCRATES' APHORISMS*

By M. SCHOLTZ, M. D.

Arcadia

SECTION FOUR (Continued)

16. Let people in good health
Beware of Hellebore;
It may induce convulsions
And things they will deplore.
17. Lack of appetite, heartburn and vertigo,
And a bitter taste in the mouth of the sick,
Who's free from fever, shows that he needs
An upward purge, both strong and quick.
18. Pains above the diaphragm
Call for purging upward;
And those below it,
For purging downward.

19. The sick, who don't develop
Thirst, while being drained,
Should be continued drained,
Until thirst be attained.
20. If a man without fever
Is seized with a gripe,
Pains of the loins and heaviness of the knees,
For a downward purging he is ripe.
21. Spontaneous passing of black blood-like feces,
With or without fever, is of ill import;
But, if this color does improve from drugs,
And color changes, it's a harmless sort.
22. Passed up or down,
Bile that is black
Early in illness,
Spells death, alack!
23. In persons wasted by a wound or disease,
Acute or chronic, whatever be the cause,
The passing of black bile or blood presages:
Next day the patient's life shall close.
24. If the passing of black bile shows up
At dysentery's very start,
It's a dire sign that does portend:
The sick shall from this world depart.
25. A bloody discharge upward, of any cause,
Is a sign of danger, but with black feces
And a bloody discharge downward
The fatal danger much decreases.
26. If a sick with dysentery
Is passing shreds of fleshy tissue,
It is an ominous portent
Of the approaching fatal issue.
27. If a sick with fever, no matter of what nature,
Sustains a copious hemorrhage,
It's likely he will be affected
With a flux of bowels in convalescent stage.
28. Whenever deafness supervenes,
All bilious discharges stop,
And vice versa deafness ceases
Whenever a bilious flux comes up.
29. The chills that come
On the sixth day
Develop crises
Hard to allay.
30. If in a paroxysmal illness
The daily fever spells recur
At the same hour every day,
Grave crises oft occur.
31. In the fevered sick who are oppressed
By a sense of weariness,
Deposits around joints and jaws
Develop more or less.
32. If a convalescent from a sickness
Develops pains in any part,
An infiltration or an abscess
May be suspected there to start.
33. But if the fixed pain of a part
Precedes the onset of disease,
The morbid process settles there
And strikes this part with greatest ease.

413 Longden Avenue.

(To be continued)

* For other aphorisms, see CALIFORNIA AND WESTERN MEDICINE, March 1940, page 125; April 1940, page 179; May 1940, page 231; July 1940, page 35; August 1940, page 85; September 1940, page 130.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION†

HARRY H. WILSON.....President
HENRY S. ROGERS.....President-Elect
LOWELL S. GOIN.....Speaker
PHILIP K. GILMAN.....Council Chairman
GEORGE H. KRESS.....Secretary and Editor

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3. *Committee on Postgraduate Activities.*
4. *Committee on Public Health Education.*
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11. *Nevada State Medical Association.*

OFFICIAL NOTICES

Correction of Error: In Minutes of House of Delegates

The minutes of the meetings of the House of Delegates for the meetings held at Coronado, May 5, 1940, as taken from the transcript made by the electric recorder (page 88 of the transcript), contained two errors, which appear also in CALIFORNIA AND WESTERN MEDICINE, in the issue of June, 1940, on pages 271 and 272.

On page 271, in the last paragraph, Speaker Lowell S. Goin is stated to have recognized Doctor Ruddock, but it was Dr. E. T. Remmen to whom the Speaker gave the floor.

In the opening paragraph on page 272, Doctor Ruddock's name appears again, as the sponsor of two proposed amendments to the Constitution, which for reference purposes were given numbers VI and VII.

The two amendments (VI and VII) were submitted by Dr. E. T. Remmen.

The proper corrections have been made in the electric recorder transcripts of the Central Office.

CALIFORNIA INDUSTRIAL ACCIDENT COMMISSION: IMPORTANT RESOLUTION*

Involves Vital Principles: (1) Possession of Private Property (Medical Records); and (2) Confidential Physician-Patient Relationship

On October 16, 1940, the Industrial Accident Commission of the State of California, without prior notice, promulgated a new ruling concerning medical records, of interest to all physicians and hospitals.

† For complete roster of officers, see advertising pages 2, 4, 6.

* For editorial comment, see page 254.

For the information of members of the California Medical Association, space is given for the presentation of the items which follow, which appear below in the sequence here given:

I. Text of resolution, dated October 16, 1940, adopted by the Industrial Accident Commission of California.

II. Informative statement, dated October 25, 1940, from the San Francisco *Recorder* (quotes statements made by G. G. Kidwell, Chairman of the Industrial Accident Commission).

III. Letter, dated November 1, 1940, from California Medical Association Council Chairman Gilman to the Industrial Accident Commission (outlining objections and requests of the organized medical profession).

IV. Reply, dated November 4, 1940, to Council Chairman Gilman's letter. By the Industrial Accident Commission, through W. F. Beem, Chief of the Compensation Bureau.

V. Opinion, dated November 14, 1940, to Council Chairman Gilman, from Legal Counsel Messrs. Hartley F. Peart and Howard Hassard.

VI. Letter, dated November 15, 1940, to Council Chairman Gilman, from Industrial Accident Commission, through W. F. Beem, Chief of Compensation Bureau (indicating possible modifications in application of the Commission's rule).

VII. Letter, dated November 19, 1940, to Industrial Accident Commission, in care of W. F. Beem. From Council Chairman Gilman (indicating need of further modification of the rule).

I

(COPY)

Resolution Adopted by the Members of the Industrial Accident Commission at a Meeting Held Wednesday, October 16, 1940

The Commission, having considered the problem, is of the opinion that it is necessary for the proper functioning of the Industrial Accident Commission and the prompt and proper determination of litigated cases before the Industrial Accident Commission that medical reports, x-rays, and hospital records be made available to the opposing side, regardless of whether or not a formal claim has been filed.

Now, Therefore Be It Resolved, That the Rules of Practice and Procedure of the Industrial Accident Commission, effective January 7, 1933, be amended, effective at once by the addition of the following rule, to be identified as Section 3 of Subdivision 18, as follows:

In all cases where an industrial injury occurs, the injured employee and his authorized agents, including attending or examining physicians and attorney, shall be given access to all medical reports, hospital records, and x-rays whether in the possession of the attending or examining physicians, the employer, the hospital, or the insurance carrier, and they may make copies of the same. The employer or insurance carrier shall file promptly with the Industrial Accident Commission all reports of all physicians appointed by the employer or insurance carrier and send one copy of each of said reports to the applicant's attorney or other representative, and if there be no attorney or other representative, to the employee. Medical reports and x-rays, obtained by or on behalf of the injured employee, shall likewise be made available to the employer, or his insurance carrier. All such reports shall be filed with the Industrial Accident Commission and a copy thereof with

the employer or his insurance carrier. The employer and insurance carrier and the employee shall, on request of the Industrial Accident Commission or referee thereof, file all x-rays with the Industrial Accident Commission.

II

(COPY)

California Accident Commission Orders Public All Medical Reports

In what was described as one of the most important steps in the history of the California Industrial Accident Commission, affecting the welfare of the 300,000 workmen injured annually in the state, the Commission yesterday issued a sweeping order making available to the injured persons or their representatives the medical records obtained by employers or insurance carriers.

Heretofore the records have been available only in the event the workmen took their claims before the Commission, and then only when actual hearings started.

The action was in accord with a recommendation of the State Bar as long ago as 1934, after a special committee had investigated the procedure of the Commission for two years. Although the then members of the Commission favored the recommendation, the former conditions continued to prevail.

In announcing the action of the Commission, George G. Kidwell, chairman, declared the new order will effect a "tremendous saving in time of Commission referees and will enable them greatly to expedite their findings."

The order, he said, was in accord with the policy of the present administration to function for the benefit of the injured workers in the state and for whom industrial accident insurance laws were enacted.

The Commission's order was in the form of a resolution which provides that in all cases where an industrial injury occurs, the injured employee and his authorized agents, including attending physicians, shall be given access to all medical reports, hospital records and x-rays taken by physicians employed by the employer or insurance company.

All physicians' reports also must be filed with the Industrial Accident Commission.

Kidwell announced that all insurance carriers operating in the state are being notified of the resolution.

Many of the large industrial states, such as Illinois, New York, Pennsylvania, and Ohio, long have had similar regulations, Kidwell declared.

"This is one of the most important procedural actions in the history of the Commission.

"It is a definite end of the policy that the medical reports were no business of the injured man."

The procedure, he said, will serve to eliminate the element of surprise at Commission proceedings in which it has been possible for a man, injured years before and relying on one current examination by a physician of his own choosing, to be confronted suddenly with the accumulated records of insurance carriers.

Such situations almost invariably resulted in request for delays to meet the presentations, and then subsequent delays for the insurance carrier to meet the newer evidence of the applicant, Kidwell declared.

"The resolution is based on the broad principle that by no theory of reason, medical ethics or legal principles should the employee be kept in the dark as to what the doctors find or recommend for him," Kidwell said.

"The procedure will avoid misunderstandings, and in case of disputes the employee can enter hearings with a full knowledge of the evidence to date and the case can be concluded in one hearing."

The essential factor, the Commission Chairman said, is that of speeding the hearing of cases and the awarding of industrial accident compensation in disputed cases.—San Francisco Recorder, October 25, 1940.

III

(COPY)

November 1, 1940.

Division of Industrial Accident Commission
Department of Industrial Relations
State of California
State Building, Civic Center
San Francisco, California

Subject: Resolution adopted by Commission, October 16, 1940, adding Subdivision 18 to Section 3 of Rules of Practice and Procedure of the Commission.

Gentlemen:

The undersigned, California Medical Association, is a voluntary association composed of over six thousand doctors of medicine practicing medicine and surgery in the State of California, and, on behalf of its members, this communication is addressed to you.

It has come to the attention of the Association and its officers and members that the Industrial Accident Commission, at a meeting held Wednesday, October 16, 1940, added Subdivision 18 to Section 3 of its Rules of Practice and Procedure and that the effect of said Subdivision 18 is to open to public inspection all medical reports, hospital records, and x-ray films in the possession of attending physicians on the demand of any agent of any injured employee and prior to the filing of a claim with the Commission.

We believe it to be obvious that the doctors of medicine practicing their profession in this State are vitally affected by the rule above mentioned. The rule, as now phrased and in the absence of proper interpretation, may result in forced disclosures of confidential communications between physician and patient. Further, the rule is stated in such broad and general terms that it is quite possible that it may be used by individuals who have no bona fide industrial claim but who desire to pry into the confidential relationship between physician and patient. In other words, we feel that the rule will not only authorize, but encourage "fishing expeditions" on the part of individuals who, in fact, have no moral or legal right to secure confidential records. This is necessarily so because the rule, as adopted, applies to medical reports and x-rays even prior to the filing of a proper claim before the Commission.

It is our understanding that your purposes and objects in adopting the rule did not directly or indirectly involve the points presented in the preceding paragraph, but that, on the contrary, your purpose was to enable claimants and their attorneys or representatives to have access to documentary evidence to be used at the hearing within a reasonable time prior to the hearing so as to avoid the element of surprise. If this understanding of your purpose is correct, we desire to make it clear that we have no objections of any kind to any regulation confined to the accomplishment of such purpose. However, the medical profession does object to any rule which goes beyond the purpose previously mentioned and, in effect, destroys the confidential nature of the physician-patient relationship.

Therefore, may we respectfully request that a hearing or rehearing, as the case may be, be had with respect to said rule adopted October 16, 1940, and designated as Subdivision 18 of Section 3 of the Rules of Practice and Procedure of the Industrial Accident Commission, and that such hearing or rehearing be held at such time and place as may be determined by you.

We further respectfully request that at said hearing or rehearing the California Medical Association be granted an opportunity to present its reasons for desiring a revision of the rule as adopted, and that, pending such hearing or rehearing, the operation of the rule be temporarily suspended.

This request and petition for a hearing before you is based upon the grounds hereinabove set forth and, as previously stated, is intended to be limited to a request for such revision of the terminology of the rule as adopted as will protect the members of the medical profession from searches and seizures of their private and personal records and files, including all case histories, records, x-ray reports and other documents, which have not been prepared for the express purpose of use as evidence in any litigation.

Respectfully submitted,

CALIFORNIA MEDICAL ASSOCIATION.

By Philip K. Gilman, M. D.,
Chairman of the Council.

IV
(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL ACCIDENT COMMISSION
STATE BUILDING

San Francisco, November 4, 1940.

P. K. Gilman, M. D., Chairman
California Medical Association
Four Fifty Sutter, Room 2004
San Francisco, California

Re: Resolution adopted by Commission October 16, 1940,
adding Subdivision 18 to Section 3 of Rules of Practice
and Procedure of the Commission.

Dear Doctor Gilman:

We have your letter of November 1, 1940, and before discussing details, I wish to make a few observations.

The writer had previously been advised indirectly that the insurance carriers were attempting to seek the aid of various medical groups to combat the resolution of October 16, 1940, referring to the filing and serving of medical reports. Subsequently, we are in receipt of letters from various hospitals and medical groups from different locations in the northern part of the state, and from the similarity of the relief requested, it seems obvious to the writer that they have been circularized. If the above is true, it may well be that the situation has not been fairly presented or understood by the different groups.

Speaking generally, the relationship between doctor and patient is well known in most civilized countries, and about the only exception with which I am familiar is that which has previously existed in the State of California for approximately thirty years under the Workmen's Compensation laws whereby the relationship exists more between the insurance carrier and the doctor than between the patient and the doctor. I can frankly state that I have never known any individual who is not in some way connected one way or the other to influence his judgment, who did not consider this arrangement archaic and most unjust. As a matter of fact, most of the large industrial centers of the East have had several rules in effect for many years, and these rules are now rather obsolete because of further changes whereby the employee now chooses his own doctor and the insurance companies have to worry about how to obtain the detailed information with reference to the doctor's findings.

It would not be feasible to write separate letters in answer to each communication that we have received, and as they are quite similar, I am asking the representative groups to accept a copy of this letter in answer to their individual communications.

Most of the letters request that the amendment to the Rules of Practice and Procedure be temporarily suspended until a hearing can be held on the subject matter generally. So far as can be ascertained, the Commission has adopted rules of procedure from time to time, beginning as early as 1918, and I can find no record of any public hearings having been held or conferences outside of the Commission and its staff in any instance, and no protests were made. The law itself does not provide for hearings with reference to rules of procedure, and the recent amendment was considered by the Commission in the customary manner. It having been formally adopted, it remains the rule of the Commission until amended or set aside by a court order. Many letters have been read to the Commission asking this same relief, and the Commission has indicated that they consider the rule proper and there is no present indication to suspend or amend it.

It so happens that the Ocean Accident and Guarantee Corporation is filing a formal petition for rehearing at-

tacking the rule on various grounds, and the Commission will have occasion to make a formal order either granting or denying the relief. It is possible that the Ocean Accident and Guarantee Corporation will then take the matter to the courts, which will result in a judicial opinion.

It is the writer's opinion that the rule is not at all inconsistent with the confidential nature of the physician-patient relationship and that, as a matter of fact, the previous rule whereby the patient was kept entirely in the dark as to the findings of the physician was entirely inconsistent with this relationship.

In considering the rule, the rule has to be in general terms and cannot contain within itself dozens of exceptions such as a different rule where, in the opinion of the attending physician, it would not be for the best interests of the employee to have him apprised of the contents of the report. Such situations only occur occasionally and, while the writer has not consulted with the Commission on such details, I cannot believe that the Commission would attempt to enforce the rule literally in a case where it would be apparent that its enforcement would be disastrous.

The principal purpose of this rule, of course, is to enable the attorneys and their representatives to have access to documentary evidence prior to the hearing in order to avoid the element of surprise and undue continuances and delays. The principal reason for the inclusion of all reports, regardless of whether or not an application is pending, is to have complete data for statistical purposes. In non-litigated cases this data will be treated as confidential and will not be shown to anybody at all by members of the staff, and I know of no real basis for any alarm over the suggestion of difficulty over searches and seizures of private records.

It is the hope of the writer that interested parties will recognize the reasonableness of the rule and will, by their actions, indicate an attitude of complete coöperation.

Unfortunately, several groups, particularly certain insurance carriers, have indicated a lack of willingness to abide by the rule and this may result in the adoption of further rules, and possibly the enactment of legislation which simply means further complications and details that would not be necessary if the parties had adopted a different policy.

I have had conferences with several very able attorneys who are thoroughly familiar with the various problems, and I recall no instance where an attorney believed that this rule would in any way jeopardize the medical profession in their calling.

Very truly yours,

(Signed) W. F. BEEM,
Chief, Compensation Bureau.

✓ ✓ ✓

V
(COPY)

San Francisco, California
111 Sutter Street

Re: Industrial Accident Commission: Subdivision 18, Section 3, of Rules of Practice and Procedure (adopted October 16, 1940).

November 14, 1940.

California Medical Association
450 Sutter Street
San Francisco, California
Attention: Philip K. Gilman, M. D.
Chairman of the Council.

Dear Doctor:

We have examined the above-mentioned rule of the Industrial Accident Commission, together with your letter of November 1, 1940, and Mr. Beem's reply dated November 4, 1940.

In our opinion, the Industrial Accident Commission of the State of California lacks legal power to require any physician or any hospital to surrender or disclose records to anyone, except in obedience to a subpoena duly issued by the Commission and except at a hearing before the Commission or a referee thereof at which a physician or an employee of a hospital is a witness. Our opinion is based upon the fact that hospital records and physician's office records, case histories, x-ray films, and laboratory reports, are private property and that both the Constitution of the United States and the Constitution of the State of California forbid the taking of private property without due process of law. In addition, we find nothing in the statutes of the State of California granting the Industrial Accident Commission any jurisdiction over private physicians or private hospitals, unless there is a claim pending before the Commission and a subpoena issued by it and except for *statistical reports* under Section 6407 of the Labor Code.

We are informed that the Commission recognizes the foregoing constitutional principles and that it does not intend to attempt to enforce its rule unless there is a pending claim and an actual hearing.

Of course, it must be understood that any written report prepared by a physician for an insurance company, an employer, or an employee, and submitted to the person for whom it is prepared, thereby becomes the property of the recipient and may be within the jurisdiction of the Industrial Accident Commission. This may be the case even though the report is returned to the physician for safekeeping or even though it is orally transmitted and the report itself retained by the doctor.

Very truly yours,

(Signed) HARTLEY F. PEART
HOWARD HASSARD

✓ ✓ ✓

VII

(COPY)

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
INDUSTRIAL ACCIDENT COMMISSION
STATE BUILDING
SAN FRANCISCO

November 15, 1940.

P. K. Gilman, M. D., Chairman
California Medical Association
Four Fifty Sutter, Room 2004
San Francisco, California

Re: Resolution adopted by the Commission under date of October 16, 1940, affecting medical reports.

Dear Doctor Gilman:

The Commission's recent rule with reference to medical reports adopted October 16, 1940, was discussed recently with Doctor Garland, Secretary of the San Francisco County Medical Society. At that time I advised Doctor Garland that the Commission had recently authorized me to advise people generally that, for the time being, it would not enforce the rule as to nonlitigated cases. He then reminded me that your original letter did not object to the rule as applied to litigated cases and that it would be highly advisable to write you of the Commission's policy.

Your reference to forced disclosures of confidential communications between patient and physician is a large subject, but speaking generally, under the rule as presently enforced, a doctor is not involved at all, as the carrier is presumed to file and serve copies of all reports as soon as an application has been filed, and a copy served upon it, and as the employee or his attorney then has the complete record, there is no occasion to call upon the doctor or bother him in any way.

You may rest assured that the Commission does not have any intention or desire to embarrass the members of

the medical profession through searches or seizures of their personal or private records. It is most difficult to discuss this problem freely without stating things that may be misunderstood or exception taken. If you could realize how many things certain adjusters can think of in order to avoid the intent of the rule, you could realize that it was necessary to make the rule rather broad. The thought had been expressed that carriers would not keep medical reports in their file at all, but would allow the doctors to retain them in the doctors' files in order to avoid application of the rule. One of the purposes of drawing the rule in the form in which it was to avoid that possibility.

Very truly yours,

(Signed) W. F. BEEM,
Chief, Compensation Bureau.

✓ ✓ ✓

VII

(COPY)

November 19, 1940.

Re: Commission's Resolution of October 16, 1940, adding Subdivision 18 to Section 3 of Rules of Practice and Procedure.

W. F. Beem, Esq.
Chief, Compensation Department
Industrial Accident Commission
State Building
San Francisco, California

Dear Sir:

Your letters of November 4, 1940, and November 15, 1940, have been received. I had delayed replying to your letter of November 4, because I desired to discuss its contents with the Executive Committee of the California Medical Association. Your letter of November 15 clears up most of the problems presented by the Commission's ruling and may I tender my thanks to you for your courtesy in furnishing us with a written clarification of the rule.

On behalf of the California Medical Association, I do wish to state, however, that we would greatly appreciate a modification of the rule itself so that records in physicians' offices and in hospitals are definitely not included.

Very truly yours,

PHILIP K. GILMAN, M. D.
Chairman of the Council.

CALIFORNIA COMMITTEE ON MEDICAL PREPAREDNESS†

(COPY)

CULBERT L. OLSON
GOVERNOR
STATE OF CALIFORNIA
DIRECTOR OF SELECTIVE SERVICE
PLAZA BUILDING, SACRAMENTO

November 18, 1940.

Dr. George H. Kress, Editor
Addressed.

Dear Doctor Kress:—We have received the copy of the November issue of CALIFORNIA AND WESTERN MEDICINE.

We thank you for the JOURNAL, and wish to compliment you on your coverage of Medical Preparedness. It is most

†Philip K. Gilman, M. D., 2000 Van Ness Avenue, San Francisco, is chairman of the California Committee on Medical Preparedness. Charles A. Dukes, M. D., 426 Seventeenth Street, Oakland, is a member of the American Medical Association Committee on Medical Preparedness. Roster of county chairmen on Medical Preparedness appeared in CALIFORNIA AND WESTERN MEDICINE, August, 1940, on page 86.

pleasing to see that the medical profession as a whole, and the California Medical Association in particular, are joining with us so firmly in the work that is before us.

FOR THE GOVERNOR.

R. E. Mittelstaedt,

State Director of Selective Service.

Lieutenant-Colonel Bert S. Thomas

Chief, Medical Division.

* * *

MEDICAL PREPAREDNESS: NEWS ITEMS

Medical Group Aids Defense

American Medical Association Creates Advisory Committee

Chicago, Nov. 7 (UP).—This country's defense preparations must include a medical program as well as appropriations for increased armed forces, according to *The Journal of the American Medical Association*.

To facilitate the medical profession's part in the defense program, the *Journal* said, a committee on medical preparedness has been created by the American Medical Association to cooperate with the Advisory Committee on National Defense, the Army and Navy Medical Corps, and Public Health Service.

The committee is composed of fifteen physicians, practicing in various sections of the country, and is headed by Dr. Irvin Abell, Louisville, Kentucky.

Its functions include:

1. Consideration of problems involved in supplying adequate medical personnel for military, naval, and civilian needs under any contingency.

2. Provide for adequate personnel to handle physical examinations, particularly of men conscripted for the medical service, men assigned to vocational training, and persons on relief.

3. To represent the association in conferences with the surgeon-generals of the Army, Navy, and Public Health services, and with other governmental agencies.

4. To cooperate with state committees on Medical Preparedness.

5. To receive recommendations from state committees on physicians whose services are believed necessary for maintenance of civilian health and who should, in the opinion of the committees, be exempt from military service.

6. To assist in the verification of qualifications of physicians desired for service in the Army or other national defense work.

The Journal of the American Medical Association, in announcing the composition of the national committee, gives as its aim "to prepare our nation to meet any emergency."—*San Francisco News*, November 7, 1940.

* * *

Slow Mobilizing Seen as Curb of Epidemics

Chicago, Nov. 13 (INS).—"Gradual mobilization" and "graded" physical training were editorially recommended by *The Journal of the American Medical Association* today, as a means of lessening the danger of an epidemic of infectious diseases in the United States' rapidly expanded military and naval centers.

Pointing out that "medical problems presented by mobilization are already taxing the ingenuity of those responsible for the program now pending," the *Journal* said that outbreaks of epidemics "are almost inevitable" when large numbers of men are brought together in camps under circumstances which call for arduous physical and disciplinary training.

Gradual mobilization, the *Journal* said, could be carried out in a number of different ways. "The assembly of large troop units can be developed in successive stages, beginning with small units and gradually joining these into larger units, so that early medical supervision can be more carefully carried out."

Military training or conditioning, the editorial stated, should "be so graded that the necessary 'hardening' is achieved without mass reduction of resistance to infection."—*San Francisco Call-Bulletin*, November 13, 1940.

* * *

Medical Men on Guard

Elaborate preparations have been made by the Army, Navy, and State Health departments to curtail infection among those called into national defense units.

Army and Navy medical men will make every effort to give early diagnosis and efficient treatment to service men found to be infected. Information as to the source will be transmitted to the civilian health departments wherever possible. The health departments are to isolate these sources during periods when the disease is in a communicable form.

This program is to be supplemented by an educational campaign concerning the dangers of venereal diseases, methods to prevent such infection and the proper steps to be taken by those who become infected.

Great progress already has been made in the war on syphilis and gonorrhea through far-sighted programs adopted by many of the states. Certainly, every effort should be made to continue this program during the period of national emergency.—*Sacramento Bee*, November 13, 1940.

* * *

Health Defense Need Outlined

Medical Convention Told War on Disease Vital to Preparedness

Louisville (Ky.), Nov. 13 (AP).—Four of the nation's medical leaders today declared that protection of the general health of the American people is a paramount consideration in the present drive toward national defense.

Dr. Nathan B. Van Etten of New York, President of the American Medical Association, Dr. Thomas Parran, Surgeon General of the United States Public Health Service, Commander Charles S. Stephenson of the Navy Medical Corps, and Colonel James S. Simmons of the Army Medical Corps, told the Southern Medical Association Convention the country rapidly is becoming united on a program of disease defense as well as invasion defense.

Coördination Urged

"We have come to a place where national planning seems to be a vital necessity," Doctor Van Etten said in recommending that President Roosevelt appoint a health coordinator in the Cabinet to supervise all health activities of the Federal Government except those handled by the Army and Navy, thus "fusing all departments into one less expensive to operate and eliminating the confusion of overlapping and duplication."

Doctor Parran told two thousand physicians from both the Northern and the Southern States that in the control of venereal diseases in the armed services, in the selection of the best men, particularly for the Army and Navy Air Corps, and in the prevention and control of diseases such as pneumonia and typhoid, great advances have been made in protecting the health of soldiers.

World War Lessons

Commander Stephenson and Colonel Simmons, in an interview, said that the Army and Navy "certainly have no intention of drafting physicians who are essential to the health of a community into military service."

All four of the medical men expressed belief that the problem of disease would not be as great as during the World War because of development of better methods of prevention and treatment and application of lessons learned in 1914-1918.

Dr. Hamilton W. McKay of Charlotte, North Carolina, meanwhile, was elected chairman of the Council, governing body of the Southern Medical Association. The Council is composed of one member from each state in the Association.—*Los Angeles Times*.

* * *

Ninth Corps Area: Medical Reserve Officers

The following medical reserve corps officers of the Ninth Corps Area, which comprises the states of California, Oregon, Washington, Idaho, Montana, Wyoming, Utah, and Nevada, had been ordered to active duty at the stations indicated by the Corps Area Commander, up to November 8:

Abramopoulos, Christos A., Major, San Francisco, First Military Area, Presidio of San Francisco.
Adams, Lewis N., First Lieutenant, Quinault, Washington, Second Military Area, Portland, Oregon.
Adams, Morgan K., First Lieutenant, Sanitarium, California, Fort Lewis, Washington.
Aronson, Samuel F., First Lieutenant, Seattle, Camp Murray, Washington.
Autard, Eugene J., First Lieutenant, San Francisco, Presidio of Monterey and Fort Ord, California.
Benson, Seymour, First Lieutenant, Los Angeles, Presidio of Monterey and Fort Ord, California.
Bernstein, Theodore I., First Lieutenant, Los Angeles, Presidio of Monterey and Fort Ord, California.
Bivins, Thomas E., First Lieutenant, Fort Bragg, California, Presidio of Monterey and Fort Ord, California.
Bovenmyer, Earl S., First Lieutenant, Pocatello, Idaho, Presidio of Monterey and Fort Ord, California.
Bruce, Robert A., First Lieutenant, Los Angeles, Presidio of Monterey and Fort Ord, California.
Bump, Robert I., First Lieutenant, Cheyenne, Wyoming, Presidio of Monterey and Fort Ord, California.

Calcagno, Joseph S., First Lieutenant, San Jose, California, Presidio of Monterey and Fort Ord, California.

Chandler, Willard J., First Lieutenant, Woodburn, Oregon, Vancouver Barracks, Washington.

Chapman, Edwin S., First Lieutenant, San Fernando, California, Presidio of Monterey and Fort Ord, California.

Conover, George W., Jr., First Lieutenant, Wilbur, Washington, Fort Lewis, Washington.

Crall, Herbert D., Lieutenant-Colonel, San Francisco, Surgeon's Office, Headquarters Ninth Corps Area, Presidio of San Francisco.

Dale, Earl E., Major, Edgerton, Wyoming, Third Military Area, Salt Lake City.

Davenport, Donald J., First Lieutenant, Los Angeles, Presidio of Monterey and Fort Ord, California.

Durham, Milton W., First Lieutenant, La Grande, Oregon, Fort Lewis, Washington.

Earl, Donald H., First Lieutenant, San Pedro, California, Fort MacArthur, California.

Edelson, Zanly C., First Lieutenant, San Francisco, Presidio of San Francisco.

Evans, Carvel S., Captain, Salt Lake City, Third Military Area.

Everett, Ernest G., First Lieutenant, Ashland, Oregon, Presidio of Monterey and Fort Ord, California.

Feusner, Henry D., First Lieutenant, Los Angeles, Fort Rosecrans, California.

Fey, Louis D., First Lieutenant, Seattle, Fort Lewis, Washington.

Franzi, Antoini J., First Lieutenant, San Francisco, Presidio of San Francisco.

Gardner, Elsworth L., First Lieutenant, Eugene, Oregon, Fort McDowell, California.

Gianelli, Virgil J., First Lieutenant, Stockton, California, Fort Scott, California.

Grossblat, Jacob, First Lieutenant, Los Angeles, First Military Area, Presidio of San Francisco.

Guyett, Harvey E., First Lieutenant, Idaho Falls, Idaho, Fort Lewis, Washington.

Haverstock, Richard T., First Lieutenant, Seattle, Fort Lewis, Washington.

Hickman, Harry S., First Lieutenant, Davenport, Washington, Fort Lewis, Washington.

Holtz, Paul Roscoe, Major, Lander, Wyoming, Third Military Area, Salt Lake City.

Horwitz, Emanuel, Captain, Alcatraz Island, California, Fort McDowell, California.

Huntington, William H., Lieutenant-Colonel, Portland, Oregon, Fort Lewis, Washington.

Isaac, Ralph W., First Lieutenant, Pomeroy, Washington, Vancouver Barracks, Washington.

Jackemy, Edward J., First Lieutenant, Oakland, California, Presidio of Monterey and Fort Ord, California.

Jumblatt, Albert, Captain, Pacific Beach, California, Fort Rosecrans, California.

Kington, George R., First Lieutenant, Wenatchee, Washington, Fort Lewis, Washington.

Konigsberg, Jerome, First Lieutenant, San Francisco, Presidio of Monterey and Fort Ord, California.

Larson, Rudolph V., Captain, Smithfield, Utah, Fort Lewis, Washington.

Lee, George F., Captain, Union, Oregon, Fort Stevens, Oregon.

Levan, Norman E., First Lieutenant, Los Angeles, First Military Area, Presidio of San Francisco.

Lind, Laurie P., Major, Portland, Oregon, Second Military Area.

Lloyd, Robert E., First Lieutenant, San Francisco, Fort Lewis, Washington.

Maguire, Joseph F., First Lieutenant, Ventura, California, Presidio of Monterey and Fort Ord, California.

McDonald, Frank J., Captain, Bakersfield, California, Presidio of Monterey and Fort Ord, California.

Mello, Henry G., First Lieutenant, Alameda, California, Presidio of Monterey and Fort Ord, California.

Nelson, Walfred A., First Lieutenant, Salt Lake City, Salt Lake City, Utah, Recruiting Officer.

Newsom, Samuel J., Captain, Walla Walla, Washington, Fort Worden, Washington.

Ohlmacher, Joseph P., First Lieutenant, Missoula, Montana, Fort Lewis, Washington.

Osgood, Samuel B., First Lieutenant, Grants Pass, Oregon, Presidio of Monterey and Fort Ord, California.

Pedersen, Christian B., Major, Tahoe, California, First Military Area.

Qualheim, Clarence B., Captain, Seattle, Fort Lewis, Washington.

Rich, David R., First Lieutenant, La Grande, Oregon, Fort Lewis, Washington.

Robbins, Carl William, Lieutenant-Colonel, Eugene, Oregon, Fort Lewis, Washington.

Rogers, Thomas J., First Lieutenant, Los Angeles, Presidio of Monterey and Fort Ord, California.

Sawyer, Malcolm H., First Lieutenant, North Twin Falls, Idaho, Third Military Area.

Sender, Walter P., Captain, San Francisco, First Military Area.

Shaefer, J. H., Lieutenant-Colonel, San Francisco, Surgeon's Office, Headquarters Ninth Corps Area, Presidio of San Francisco.

Sharp, Paul W., First Lieutenant, Klamath Falls, Oregon, Fort Lewis, Washington.

Shier, Cyril W., Captain, Arcadia, California, Presidio of Monterey and Fort Ord, California.

Sirbu, Abraham B., First Lieutenant, San Francisco, Presidio of Monterey and Fort Ord, California.

Sprague, Norman F., First Lieutenant, Beverly Hills, California, Presidio of Monterey and Fort Ord, California.

Stranquist, Henry C., Major, Ogden, Utah, Third Military Area.

Szukalski, Joseph P., First Lieutenant, Pasadena, California, First Military Area, Presidio of San Francisco.

Ten Eyck, Thomas G., Captain, Portland, Oregon, Fort Lewis, Washington.

Thomas, Leon B., Captain, Vancouver, Washington, Fort Lewis, Washington.

Thompson, Roger S., Captain, Seattle, Camp Murray, Washington.

Tichenor, Ernest LaPoint, Captain, Fort Belknap, Harlem, Montana, Third Military Area, Salt Lake City.

Toppenberg, David R., First Lieutenant, Loma Linda, California, Presidio of Monterey and Fort Ord, California.

Velonis, Stamatis G., First Lieutenant, Nespelem, Washington, Fort Lewis, Washington.

Vogt, Paul R., First Lieutenant, The Dalles, Oregon, Fort Lewis, Washington.

Whitaker, Clifford W., Major, Tacoma, Washington, Second Military Area, Portland, Oregon.

White, Alfred S., First Lieutenant, San Francisco, Presidio of Monterey and Fort Ord, California.

Wolf, Robert W., First Lieutenant, San Francisco, Presidio of San Francisco.

Zener, Francis B., Major, Portland, Oregon, Vancouver Barracks, Washington.

* * *

Liaison Medical Officer for the Ninth Corps Area

Nine Public Health Service officers have been assigned to special medical duties in connection with military camps now being set up under the Selective Service Act, according to Surgeon General Thomas Parran.

Environmental sanitation with emphasis on the control of the communicable diseases will be the chief responsibility of the newly assigned public health officials. "To safeguard the health of America's young men who are receiving military training, it is necessary to have proper health conditions in the areas surrounding the camps as well as in the camps themselves," Doctor Parran stated.

Through agreement between the public Health Service and the Army the liaison officers are being assigned to the nine Army corps areas to work with the corps area surgeons and will act as intermediaries in the problems arising in extra-military areas—problems of concern to state health departments, local health departments, and agencies of allied aims.

The agreement between the Army and the Public Health Service to use these liaison officers came as a result of recognition of the public health relationships involved in the cases of infectious disease in military areas, in the handling of food, the disposal of garbage and sewage, and in the water supply.

The most serious hazard that the new draftees will face is from the communicable diseases. A much better record may be expected now in this respect than during the World War because housing provisions for soldiers will be more adequate than they were at that time and because of the added safeguards now being provided.

Dr. Edgar W. Norris has been assigned to the Ninth Corps Area (Pacific States).

* * *

This Is Not a New Story

During the World War the combined efforts of the Army, the Navy, the civil health and law enforcement officials, the American Social Hygiene Association and cooperating agencies prevented the huge increase in syphilis and gonorrhea which has accompanied every other war in history.

The United States forces had less venereal disease than any nation in the war. But—in spite of this fine record—

... There were 157,146 more new cases of syphilis and gonorrhea among the United States soldiers, sailors, and marines than there were wounds in battle.

... Nearly seven and a half million sick days were lost on account of these diseases ... or the equivalent of 20,600 men absent from service for a whole year. ...

... In terms of service, enough days were lost to man five huge aircraft carriers and nine destroyers, or twenty regiments of infantry for the entire period of the war.

"The Enemy Within Our Lines"

Since the World War a continuous program of education, early diagnosis, and prompt treatment has forced the venereal disease rates steadily downward among United States soldiers and sailors. Yet syphilis and gonorrhea still remain major causes in "sick report" and "absence from duty."

For 1937, the Surgeon-General of the Army reported:

"More than three times as many days lost from syphilis and gonorrhea than from any other cause. ...

"Gonorrhea was the second, syphilis the fifth, most frequent reason for sickness. Together these diseases were exceeded on the sick list only by influenza. ..."

Extensive study of these diseases among industrial and other civilian groups shows even greater losses in time and efficiency. ...

Now, as in 1917, syphilis and gonorrhea are still "the enemy within our lines."

As national mobilization becomes a fact, the problem, of course, will grow greater. Infections among soldiers and sailors and industrial workers in turn spread infection in American homes and families.

We run the danger not only of wasted manpower among the nation's defenders, but also of losing much of the splen-

did health gains made among mothers, children, and young people in the past few years, unless we tackle this new problem squarely and without delay.

America's health is America's strength!

* * *

Shell Shock and War Neuroses*

The term "shell shock" has been loosely applied to a great variety of nervous and mental disorders occurring among soldiers during times of war. Authorities everywhere are agreed that shell shock is not a specific disease entity. Its symptoms and mechanisms are in the main the symptoms and mechanisms of the ordinary psychoneuroses (chiefly hysteria) well known to all psychiatrists. The stresses and horrors of war serve merely as the precipitating factors in producing nervous afflictions in already neurotically disposed individuals.

Of course, numerous soldiers suffer severe concussion of the brain and spinal cord, presumably by air pressures and vacuums created when large caliber shells explode very near them. In this way may be produced actual internal organic damage, usually demonstrated by bloody cerebrospinal fluid under increased pressure, and various neurological signs denoting central nervous system injury. But these cases, sometimes designated as "true" shell shock are readily distinguishable from the overwhelming majority of purely functional conditions.

To these functional forms of shell shock is generally applied the term "war neuroses," which the accompanying table attempts to elucidate.

* For letter of transmittal from J. C. Geiger, M.D., Director of Public Health, San Francisco, see page 309.

War Neuroses

* Predisposing Factors	Common Types and Symptoms	Illustrations	Differential Diagnosis and General Comment	Treatment
Constitutional predisposition as deduced from: (1) History of mental instability in family, including insanity, epilepsy, alcoholism, and general "nervousness." (2) Past personal history of emotional instability or neurotic symptoms, including: Previous "nervous breakdown" Chronic alcoholism Tendency to temper tantrums Eneureis Nightmares Sleepwalking Frequent headaches of unknown etiology Moodiness Seclusiveness Fears Anxiety—tension Nail-biting Excessive shyness and hypersensitivity Excessive religious tendencies (3) The abnormal environment in the war situation. Comment: Immediate existing causes are often of minor significance. True, in many cases there is a history of the soldier being "blown up" or buried, but in most cases no organic injury was suffered and many cases of "shell shock" developed in soldiers nowhere near the front.	Most common are: Hysterical manifestations such as functional monoplegias, hemiplegias, tics, mutism or aphonia, amnesia, blindness, deafness, anesthesia, choreiform movements, contractures, tremors, etc. Also seen are: Neurasthenic reactions characterized by constant state of fatigue and lassitude, headache and pressure sensations, various vague somatic complaints as palpitation, tingling, etc. Anxiety states. Obsessions and compulsions. Phobias (fears). Hypochondriasis—excessive somatic preoccupation giving rise to myriads of incapacitating physical complaints.	A soldier sees a companion blown to bits, is horrified, closes his eyes to shut out the sight; then remains functionally blind. ... He is temporarily deafened by a shell explosion, then remains functionally deaf. ... He is ordered "over the top." His legs become paralyzed and he cannot move forward. ... There is a terrific bombardment; he is frightened and bewildered. The situation is intolerable. He escapes from it by losing his memory—amnesia. ... He is having bayonet practice. The idea of gutting another man is abhorrent, and the arm directing the bayonet becomes numb and paralyzed and remains so for the duration of the war. ... The constant hardship and nervous tension produced by the war situation results in physical fatigue, insomnia, and fears engendered by persistent threat to life. The neurotically predisposed soldier cracks under the strain. He becomes a "physical wreck" with a multitude of complaints and incapacities.	Malingering constitutes the chief obstacle in the diagnosing of the true war neuroses. In establishing a diagnosis there is no short cut from a careful investigation of the case history and a thorough examination. Hysterical manifestations can likewise be distinguished from organic disturbances by careful neurological examination. (The service of a competent neuropsychiatrist is often required.) It must be emphasized that soldiers who develop hysterical disabilities are not malingerers. The whole process is unconscious (malingering is conscious) even though it fulfills a real wish and a purposive escape from danger and an intolerable reality. The mechanism in brief is this: Presence of external stress (war situation), inability to adjust, unconscious inner conflict, regression to instinctual reaction, defense symptom formation, and finally escape from threatening danger.	There is no one generally accepted treatment. Removal from the environment of stress and conflict cures some. General methods of physical, occupational and psychotherapy in base hospitals cure others. Still others are benefited most by being forced to remain under strict military régime. Hypnotism, persuasion, or suggestive measures accompanied by Electroshock therapy often produce cures in an amazingly short time. The personality of the medical officer is a very important factor. Delay in treatment allows fixation of the neurosis and once a soldier becomes "fixed" with his symptoms his services can seldom be utilized again.

* The consideration of these predisposing factors is of extreme importance, particularly in times of mobilization. By weeding out the potentially unfit in the recruiting stations, the government could be spared the expenditure of millions of dollars later in caring for the "veterans" who develop "nervous" ailments while in the service.

COMMITTEE ON POSTGRADUATE ACTIVITIES†

Course for General Practitioners: The Clinical Aspects of Dermatology

The University of California Medical School, Medical Center, San Francisco, on January 6 to 8, 1941, will give a three-day refresher course on "The Clinical Aspects of Dermatology."

Outline of course follows:

Monday, January 6, 1941

- 9:00 a. m.—Dermatologic Manifestations of Systemic Disease—H. E. Miller, M. D.
- 10:00 a. m.—Vitamin Therapy in Dermatology, F. G. Novy, Jr., M. D.
- 11:00 a. m.—Treatment of Acne—E. A. Levin, M. D.

CUTANEOUS MALIGNANCY

- 1:00 p. m.—Precancerous Skin Conditions—Differential Diagnosis from Benign Growths, Frances A. Torrey, M. D.
- (a) Cause, (b) Characteristics, (c) Treatment
- 2:00 p. m.—Cutaneous Malignancy—H. G. Bell, M. D., R. S. Stone, M. D., and Frances A. Torrey, M. D.
- (a) Diagnosis, (b) Characteristics, (c) Therapy (curette and desiccation, surgery, x-ray, and radium), (d) Follow up
- 3:00 p. m.—Demonstration of Cases—H. G. Bell, M. D., R. S. Stone, M. D., and Frances A. Torrey, M. D.

Tuesday, January 7, 1941

- 9:00 a. m.—Principles of Treatment of Syphilis—N. N. Epstein, M. D.
- (a) Early Syphilis, (b) Latent Syphilis, (c) Late Syphilis
- 10:00 a. m.—Interpretation of Laboratory Tests for Syphilis—R. A. Stewart, M. D.
- (a) Dark Field, (b) Blood Wassermann and Kahn (c) Spinal Fluid
- 10:30 a. m.—Discussion of the Indications for the Use of Certain Drugs in the Treatment of Syphilis—E. A. Levin, M. D.
- 11:00 a. m.—Fever Therapy as an Adjunct in the Treatment of Neurosyphilis—N. N. Epstein, M. D.
- 11:30 a. m.—Five-Day Treatment of Syphilis—N. N. Epstein, M. D.
- 2:00 to 4:00 p. m.—Skin Problems in Children, Ward 17, San Francisco Hospital—F. S. Smyth, M. D., W. C. Deamer, M. D., A. U. Christie, M. D., and S. N. Zuckerman, M. D.

Wednesday, January 8, 1941

- 9:00 a. m.—Demonstration of Dermatological Cases—H. E. Miller, M. D.
 - 10:30 a. m.—Present Status of Poison Oak Immunization—J. M. Graves, M. D.
 - 11:15 a. m.—Dermatophytosis—R. A. Stewart, M. D.
 - 1:00 p. m.—Dermatology and Industry—H. E. Miller, M. D.
 - 2:00 p. m.—Allergy in Dermatology.
 - 3:00 p. m.—Dermatologic Therapy—N. N. Epstein, M. D.
- Dr. S. R. Mettler, Associate Professor of Medicine, in charge.

Registration.—Students may register by mail. Checks (\$20, payable to the Regents of the University of California) should be sent to the Dean's Office, University of California Medical School, Medical Center, San Francisco. In order that arrangements may be made, it is desirable that all checks be received by the Dean's Office not later than December 31, 1940.

This short comprehensive course is designed to meet the needs of physicians engaged in private practice. Many of the discussions will be illustrated by patients, lantern slides or pathological material. Meetings, except on Tuesday afternoon, will be held in Toland Hall, first floor, University of California Hospital, San Francisco.

Physicians enrolled in the course will be welcome to use the facilities of the Medical School Library.

* * *

Southern California Medical Association

The one hundred and third semi-annual meeting was held on November 15 and 16, 1940, with headquarters at the California Hotel, San Bernardino.

†Requests concerning clinical conferences, guest speakers, and other information, should be sent to the California Medical Association headquarters office, 450 Sutter, San Francisco, in care of the Association Secretary, who is secretary ex officio of the Committee on Postgraduate Activities.

Program follows:

Friday Afternoon Session, November 15 2:00 p. m.

- Postural Hypotension: With Report of Two Cases—Milo K. Tedstrom, M. D., Santa Ana.
- Discussion by Philip Corr, M. D., Riverside, and Roland Cummings, M. D., Los Angeles.
- Symposium—Hypertension: Its Present Status
- Experimental Aspects—Myron Prinzmetal, M. D., Los Angeles.
- Pathologic Aspects—Edward M. Butt, M. D., Los Angeles.
- Clinical Aspects—Willard Stone, M. D., Pasadena.
- Ophthalmologic Aspects—M. N. Beigelman, M. D., Los Angeles.
- Urologic Aspects—Elmer Belt, M. D., Los Angeles.
- Moderator: Thomas Addis, M. D., San Francisco.

Friday Evening Session, November 15 8:00 p. m.

- Treatment of Nephritis—Thomas Addis, M. D., San Francisco.
- Circulatory Disturbances in the Upper and Lower Extremities—Frederick L. Reichert, M. D., San Francisco.

Saturday Morning Session, November 16 10:00 a. m.

- Intubation Management of Distension in Intestinal Obstruction—Louis C. Bennett, M. D., Los Angeles.
- Discussion by Paul G. Holder, M. D., San Diego, and Irving Wills, M. D., Santa Barbara.
- Differential Diagnosis in Low Back Pain—Vernon Luck, M. D., Los Angeles.
- Discussion by Kenneth L. Dole, M. D., Redlands, and Lawrence R. Leidig, M. D., Santa Monica.
- Surgical Treatment of Spinal Cord Tumors—C. Hunter Sheldon, M. D., Pasadena.
- Discussion by George H. Patterson, M. D., Los Angeles, and David L. Reeves, M. D., Los Angeles.
- The Puerperal Cervix—Norman H. Williams, M. D., Beverly Hills.
- Discussion by Hobart M. Kelly, M. D., Riverside, and Robert H. Fagan, M. D., Los Angeles.

Saturday Afternoon Session, November 16 2:00 p. m.

- Symposium—Non-Malignant Diseases of the Colon
- Irritable Colon—Leland Hawkins, M. D., Los Angeles.
- Amebic Dysentery—William C. Boeck, M. D., Los Angeles.
- Chronic Ulcerative Colitis—Edward C. Rosenow, Jr., M. D., Pasadena.
- Diverticulosis and Diverticulitis—J. Norton Nichols, M. D., Los Angeles.
- Polyposis—John W. Budd, M. D., Los Angeles.
- Roentgenologic Aspects—Wilbur Bailey, M. D., Los Angeles.

* * *

California Society for Crippled Children

The fourteenth annual meeting of the California Society for Crippled Children was held at the Biltmore Hotel, Los Angeles, on December 6, 1940.

Program follows:

- Medical Care and Treatment, by Dr. H. Waldo Spiers, Los Angeles.
- Lay Participation in Medical Programs, by Mr. James G. Woolley, Los Angeles.
- A Program for Spastics in California, by Mr. Chauncey H. Whitner, Oakland.
- Vocational Rehabilitation, by Mr. H. D. Hicker, Sacramento.

* * *

Eleventh Annual Postgraduate Symposium: San Francisco Heart Committee

The eleventh annual Postgraduate Symposium on Heart Disease by the San Francisco Heart Committee, 604 Mission Street, Room 802, San Francisco (affiliated with the American Heart Association and California Heart Association), was held on November 26, 27, and 28.

Program follows:

Tuesday Morning, November 26 9:00 to 12:00 Noon

- Stanford University Medical School, Stanford Hospital Lane Hall, Sacramento Street, near Webster
- J. K. Lewis, M. D., Presiding
- Clinics conducted by Arthur L. Bloomfield, M. D., Ann P. Purdy, M. D., and J. K. Lewis, M. D.
- Pathological Demonstration: Enlarged Hearts, by William Dock, M. D.

Tuesday Afternoon, November 26
2:00 to 4:30 p. m.

Stanford University Medical School, Stanford Hospital
Lane Hall, Sacramento Street, near Webster
J. K. Lewis, M. D., Presiding

- Roentgen Measurement of Heart Size: Importance of
Fluoroscopic Study of the Heart—R. R. Newell, M. D.
Cardiac Arrhythmias—William W. Newman, M. D.
Hypersensitive Carotid Sinus Mechanism—Lester Lipsitch,
M. D.
Circulation in Acute Infectious Diseases—Lowell A. Rantz,
M. D.
Treatment of Cardiovascular Syphilis—C. W. Barnett, M. D.
Differential Diagnosis of Hypertension—D. A. Ryland,
M. D.

Tuesday Evening, November 26
7:15 p. m.

University of California Medical School, University of
California Hospital—Toland Hall
Third and Parnassus Avenues

TECHNICAL DEMONSTRATIONS

Richard D. Friedlander, M. D., Presiding

- Determination of Circulation Rate—Gordon Meiklejohn,
M. D.
Diodrast Cardioroentgenology—E. R. Miller, M. D.
Cardiac Roentgen-Kymography—L. H. Garland, M.D.
Value of Coronary Artery Injection—Gerson Biskind, M. D.,
and Morton Meyer, M. D.
The Symbalophone—William J. Kerr, M. D.
Procedures in the Treatment of Peripheral Vascular Dis-
ease—John B. Lagen, M. D.
The Determination of Blood Pressure Advised by the
American Heart Association—Dudley W. Bennett, M. D.
Oxygen Therapy in Cardiac Disease—Richard D. Fried-
lander, M. D.
The Use of the Lag Screen in Electrocardiography—Francis
J. Rochex, M. D.
The Effect of Exercise on the Electrocardiogram—Arthur
Twiss, M. D., and Maurice Sokolow, M. D.
Demonstration of Simultaneous Phonocardiograms, Electro-
cardiograms, and Pulse Tracing—John J. Sampson, M. D.

Wednesday Morning, November 27
9:00 a. m. to 12:15 p. m.

University of California Medical School, University of
California Hospital—Toland Hall
Third and Parnassus Avenues

Francis L. Chamberlain, M. D., Presiding

- Evaluation of the Cardiac Risk in Pregnancy—John J.
Sampson, M. D.
Abnormal Electrocardiograms Without Heart Disease—
Francis L. Chamberlain, M. D.
Some Important Therapeutic Possibilities in Angina Pec-
toris—Harold H. Rosenblum, M. D.
Newer Aspects of Digitalis Therapy—Maurice Sokolow,
M. D.
The Heart in Military Service—Eugene S. Kilgore, M. D.
Clinical-Pathological Conference—William J. Kerr, M. D.,
and Jesse L. Carr, M. D.

Wednesday Afternoon, November 27
2:00 to 5:00 p. m.

University of California Medical School, University of
California Hospital, Third and Parnassus Avenues

Francis L. Chamberlain, M. D., Presiding

- 2:00 to 3:00 p. m.—Demonstration Clinics. (Choose one.)
Demonstration of Electrocardiograms (Arrhythmias)—
Richard D. Friedlander, M. D., Toland Hall, University
of California Hospital.
Coronary Heart Disease—Dudley W. Bennett, M. D.,
Room 437, Clinic Building.
Treatment of Hypertensive Heart Disease—Francis L.
Chamberlain, M. D., Room 422, Clinic Building.
Peripheral Vascular Disease—John B. Lagen, M. D., and
Gordon Meiklejohn, M. D., Room 415-G, Clinic Building.
Diagnosis of Luetic Heart Disease—S. P. Lucia, M. D.,
Room 434-A, Clinic Building.
Fluoroscopy—Section I—Francis J. Rochex, M. D., Room
415-J, Clinic Building.
Fluoroscopy—Section II—Charles S. Capp, M. D., X-ray
Waiting Room 346, University of California Hospital.
3:00 to 4:00 p. m.—Demonstration Clinics. (Choose one.)
Demonstration of Electrocardiograms (Coronary Dis-
ease)—Dudley W. Bennett, M. D., Toland Hall, Uni-
versity of California Hospital.
Treatment of Angina Pectoris—William J. Kerr, M. D.,
Room 437, Clinic Building.
Hypertensive Heart Disease—Harold H. Rosenblum,
M.D., Room 422, Clinic Building.

- Treatment of Congestive Failure—John J. Sampson,
M. D., Room 434-A, Clinic Building.
Rheumatic Heart Disease—Saxton T. Pope, Jr., M. D.,
Room 415-G, Clinic Building.
Fluoroscopy—Section I—F. C. Blake, M. D., Room 415-J,
Clinic Building.
Fluoroscopy—Section II—Earl R. Miller, M. D., X-ray
Waiting Room 346, University of California Hospital.
4:00 to 5:00 p. m.—Demonstration Clinics. (Choose one.)
Demonstration of Electrocardiograms (Rheumatic, Hy-
pertensive, Cor Pulmonale)—J. C. Lockhart, M. D.,
Toland Hall, University of California Hospital.
Diagnosis and Treatment of Cardiac Neuroses—Eugene
S. Kilgore, M. D., Room 437, Clinic Building.
Peripheral Vascular Disease—John B. Lagen, M. D., and
Gordon Meiklejohn, M. D., Room 415-G, Clinic Building.
Treatment of Congestive Failure—Richard D. Fried-
lander, M. D., Room 422, Clinic Building.
Heart Disease in Childhood—Amos U. Christie, M. D., and
Mary B. Olney, M. D., Room 434-A, Clinic Building.
Fluoroscopy—Section I—Maurice Sokolow, M. D., Room
415-J, Clinic Building.
Fluoroscopy—Section II—J. M. Robinson, M. D., X-ray
Waiting Room 346, University of California Hospital.

Wednesday Evening, November 27

Annual Dinner

William W. Newman, M. D., Presiding

- Brief Business Meeting and Election of Officers of San
Francisco Heart Committee.
"Harvey, the Heart, and War"—Chauncey D. Leake, Ph.D.,
Professor of Pharmacology, University of California
Medical School.
"The Heart Sounds Again"—Arranged by Harold H. Rosen-
blum, M. D.

Thursday Morning, November 28
9 a. m. to 12 Noon

San Francisco Hospital, Medical Amphitheatre
Potrero Avenue and Twenty-second Street
Charles A. Noble, Jr., M. D., Presiding

- 9:00 to 9:30—Electrocardiography, J. Marion Read, M. D.,
and Gordon E. Hein, M. D.
9:30 to 10:45—Section I, Ward Rounds; Section II, Cardiac
Fluoroscopy.
10:45 to 12:00—Section I, Cardiac Fluoroscopy; Section II,
Ward Rounds.

DOCTORS CONDUCTING CLINICS

- Stanford University Service: George D. Barnett, Lovell
Langstroth, Arthur Carol McKenney, Jr., J. Marion Read,
Edgar A. Wayburn, and Dwight Wilbur.
University of California Service: Edwin L. Bruck, Gordon
E. Hein, William J. Kerr, Clayton D. Mote, Charles A.
Noble, Jr., and Mayo H. Soley.

Thursday Afternoon, November 28

San Francisco Hospital
Potrero Avenue and Twenty-second Street

J. Marion Read, M. D., Presiding

- The Practical Management of the Cardiac Patient—LeRoy
Briggs, M. D.
Cardiovascular Requirements in Military Service—Colonel
W. H. Allen, M. C., U. S. A., Chief of the Medical Service,
Letterman General Hospital, San Francisco.
Clinical Pathological Conference.
Clinicians: Arthur Carol McKenney, Jr., M. D.; J. Marion
Read, M. D.
Pathologist: Alvan J. Cox, M. D.
Pathological Conference.
Gordon E. Hein, M. D., and Jesse L. Carr, M. D.

* * *

DISTRICT AND COUNTY POSTGRADUATE COMMITTEES*

Refresher Courses in California Medical Schools

For information concerning the dates and scope of post-
graduate courses, offered from time to time by the four
Class A undergraduate medical schools of California, re-
quest should be made to the Deans or Registrars of those
institutions:

University of California Medical School, Medical Center,
San Francisco.

* Space was reserved for announcement of a proposed
refresher course on Military Medicine, to be conducted at
San Diego, in connection with the Army, Navy, Aviation,
and Marine Corps reservations located in that district.
The tentative dates were changed. The space is used to
present information on ways and means in which refresher
courses may be conducted.

Stanford University School of Medicine, 2398 Sacramento Street, San Francisco.

School of Medicine of the University of Southern California, 3551 University Avenue, Los Angeles.

The College of Medical Evangelists, 312 North Boyle Avenue, Los Angeles.

California Medical Association Postgraduate Committee

The courses included in the plans of the California Medical Association Committee on Postgraduate Activities, and as outlined in the CALIFORNIA AND WESTERN MEDICINE Postgraduate Supplement of October, 1938, are referred to under different names, such as: "Clinical Conferences," "Refresher Courses," or "Continuation Studies," and may be said to fall under two major heads: (1) Yearly Conferences, and (2) Continuation Courses.

Yearly Conferences:

(a) These may be one-, two- or three-day consecutive courses, given once a year or so, in a particular district; or

(b) Continuation of Planned Programs in Consecutive Courses: Part-day programs, once or twice weekly, over a period of two to eight weeks.

The above courses may be conducted as follows:

Program for a One-Day Conference:

In this plan the simplest arrangement is the one-day program, in which the work may cover the whole or part of the day, thus:

(a) Morning, Afternoon, and Evening Plan:

10-12 noon—Ward Rounds or Bedside Clinics.

2- 5 p. m.—Clinics or Round-Table Conferences.

7-10 p. m.—Clinical Presentations (patients, lantern or cinema illustrations, talks with discussions, time being divided).

(b) Afternoon and Evening Plan:

2- 5 p. m.—Ward Rounds; Round-Table Discussions.

7-10 p. m.—Clinical Presentations (as above, under a).

The type of program to be selected by a local committee will depend not only upon the local hospital or other clinical facilities (for example, willingness of physicians to bring patients), but also upon the geographical district to be covered; that is, upon the distances to be covered by the physicians taking the courses (with relationship to amount of time needed to reach the place selected for the clinical conferences, with allowance of periods in which a certain amount of private practice could be carried on).

COMMITTEE ON PUBLIC HEALTH EDUCATION†

During the past month the Committee on Public Health Education undertook a campaign with the view of having medical talks delivered by radio, either with a sponsor or as a sustaining program by the radio stations. All talks suggested for use have been secured from the American Medical Association, thus guaranteeing their accuracy and adherence to the strict ethical code of the medical profession.

Both plans already have met with success, these talks having been delivered over a period of years at station

KWG in Stockton by a commercial sponsor, and during the past several months by station KSRO at Santa Rosa as a sustaining program.

This program is being worked out at present with radio station representatives in San Bernardino, Santa Ana, El Centro, Long Beach, and San Jose. Stations in central and northern California will be contacted as rapidly as possible.

It is hoped to augment the existing programs, including those mentioned and the programs now sponsored by the Los Angeles and San Diego counties medical societies, until a blanket coverage of the entire state is secured.

Returns from the essay contest for high school and junior college students and the open scenario contest, from which material for a medical motion picture is to be selected, have been made to the Committee on Public Health Education and the entries now are being judged.

In addition to handling the detail work of the foregoing projects, the Public Relations Counsel has undertaken to assist the Woman's Auxiliary in placing *Hygeia* in the public schools of California and is handling publicity for the Medical-Dental Exposition to be held at the Shrine Auditorium in Los Angeles in February under the sponsorship of the Los Angeles County Medical Society.

R. M.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Provisions of the Basic Science Initiative again occupied the attention of the Department of Public Relations in November, with the measure moving close to completion at the end of the month. At this time there remain only a few items to be settled before a new draft of the initiative is prepared.

Principal activity on the Basic Science law last month was a meeting in San Francisco, at which Philip K. Gilman, Dwight L. Wilbur and George H. Kress, representing the Association, conferred with Ernest Sloman, dean of the College of Physicians & Surgeons, San Francisco, and secretary of the joint committee of the two state dental associations on the Basic Science Initiative. The meeting resulted in arrival on a common ground on several of the points the dentists had raised as requisites of the measure to secure approval of the two dental societies. Only four points are now under discussion, and it is expected that complete agreement on these will soon be reached. When such agreement is arrived at, the initiative measure will be in shape to be put before the dentists of the state for their approval.

Concurrence of the dentists of California in the Basic Science Initiative may mean a change of curricula for the dental schools, and for that reason the state dental societies have been very much interested in the terms of the measure. It is now believed that settlement of the few final points will soon be had, after which the initiative will be ready for preparation of the fifth draft. If this draft is acceptable to all concerned, the measure will be ready for presentation to the California State Attorney-General for titling. Once a title is secured, the act can be placed before the public for the gathering of necessary signatures to qualify it for the public ballot.

J. H.

†The Committee on Public Health Education was established through Substitute Resolution No. 6 at the Del Monte annual session, May 3, 1939.

The Committee on Public Health Education consists of Frank R. Makinson, chairman, Oakland; Philip K. Gilman, secretary, San Francisco; Samuel Ayres, Jr., Los Angeles; Thomas A. Card, Riverside; Lowell S. Goin, Los Angeles; Julius B. Harris, Sacramento; Harry H. Wilson (ex officio); Los Angeles. Mr. Ross Marshall is the Public Relations Counsel of the Committee, and may be addressed at 408 South Spring Street, Los Angeles (telephone TUCKER 2312), or 244 Kearny Street, San Francisco (telephone YUKON 2212).

†The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Donald Cass of Los Angeles is the chairman, and Dr. George H. Kress is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. George H. Kress, Room 2004, Four Fifty Sutter Street, San Francisco.

CALIFORNIA PHYSICIANS' SERVICE†

Membership

September, 1939	1,220
March, 1940	9,322
September, 1940	17,398
November 15, 1940	19,739

Among groups recently enrolled are the following: Burbank School; California Inspection Rating Bureau, San Francisco; Crown Spray Gun Manufacturing Company; Electrical Products Corporation, Los Angeles; Hooper Printing Company, San Francisco; Earl R. Lindberg Company, Oakland; Marlborough School, Los Angeles; R. L. McDonald; Mercy Hospital, Bakersfield; Pacific Grove High School; Pacific Electric Motor Company; Pineapple Producers Coöperative; Rand McNally Company; Retail Department Store Union No. 1100; Salinas City Schools; San Francisco Presbyterian Orphanage; San Joaquin County Department of Agriculture; San Pedro News Pilot; San Rafael High School; Shell Employee Group; Social Security Board—Regional Office; Turlock Grade School; United States Treasury Department (Accounts); and Ventura Union High School.

Presented herewith is information gathered from review of statistics for the month of August.

During August, when there were 16,650 dues-paying beneficiary members throughout the state, 2,460 cases were treated by 1,263 professional members. Sixteen thousand one hundred twenty-seven dollars and forty-five cents was disbursed to professional members in payment of the 12,687 units of service rendered, at a unit value of \$1.35. The average number of units of service rendered per doctor was 10.02; the average check per doctor was \$12.76.

Among the 24.8 per cent of the professional members throughout the state who participated during August, the distribution of patients was as follows:

720 doctors saw	1 patient each
276 doctors saw	2 patients each
120 doctors saw	3 patients each
60 doctors saw	4 patients each
32 doctors saw	5 patients each
17 doctors saw	6 patients each
17 doctors saw	7 patients each
10 doctors saw	8 patients each
1 doctor saw	9 patients
3 doctors saw	10 patients each
3 doctors saw	11 patients each
3 doctors saw	13 patients each
1 doctor saw	16 patients

An interesting commentary on the activity of the service is revealed in the statistical study of the cost per patient treated. Since March, 1940, analysis of this point shows that, with an average of about one thousand doctors per month treating an average of two thousand cases per month, the unit cost per case shows a remarkable consistency, as evidenced by the following table, which shows the

average number of units of service rendered per case, by months:

March	5.36
April	5.32
May	5.35
June	5.09
July	4.99
August	5.15

This shows that one of the constants, in our experience of the past year, has been the practice of physicians as it relates to a large number of cases dealing with all kinds of illnesses.

The most variable factor discovered thus far is that relating to x-ray and laboratory services, which from month to month occasionally shows startling increases. For example, in the month of June 1,404 units were required for x-ray and laboratory investigations, whereas in July 2,085 units were required for the same services. While the over-all increase in units of service required for all care was 9 per cent, the increase in laboratory and x-ray services was 48.5 per cent. The increase in cases treated for the same period was 11.3 per cent.

The unit value for September has been maintained at \$1.35, and checks for services rendered during that month have gone out to participating doctors. California Physicians' Service has now reached a point at which a reasonable allocation for administration from current revenue meets operating expenses, and it is no longer necessary to draw upon the funds made available by the California Medical Association.

Press Clippings.—Concerning the California Physicians' Service and Medical Service plans:

Physicians to Be Hosts at Dinner for Health Plan

Civic leaders, employees, cross sections of business and professional men and the employees in various industries and business houses will be invited to a public dinner next Monday evening, October 28, sponsored by the Kern County Medical Association in the interest of the California Physicians' Service Plan. Plans for the community dinner to awaken interest and support of the plan that is devised to supply medical care and hospitalization for the persons in middle and low income brackets were discussed at a meeting of the Society last night. Dr. C. S. Compton presided.

Dr. Dewey Powell of Stockton, district councilor of the California Medical Association, will be among the speakers at the community dinner as well as A. B. Rector, field representative of the California Physicians' Service.

Mr. Rector spoke before the local medical group last night, pointing out that the plan is receiving state-wide support by small and middle income groups that are willing to pay for medical and hospital care within their means. Speaking of the plan today he said:

Prevention

"The low fee charged provides for the health emergencies of the employed heads of families and the members of the families and the hospital care features of the plan have been tried out for many years with great success. The medical care supplied for heads of families, under the plan, is a big step in prevention of chronic illness and disease.

"Good health care can often keep the employed head of a family from long periods of sickness and unemployment.

"The poor are well taken care of medically and the itinerants by the government, the wealthy through their own abilities, but the middle and low-income class groups have been neglected.

Small Overhead

"This plan saves the overhead cost that regular insurance incurs and should eliminate the necessity of an \$80,000,000 tax bill from a socialized medicine plan proposed to the Legislature last year. Most employed persons want a plan whereby they can pay for their own care at a fee that is not a financial drain and still obtain the best.

"The best physicians and surgeons and hospitals in California are enrolled under the California Physicians' Service.

"The plan is not an insurance but a service organization," Mr. Rector emphasized, "and its officers and directors serve without pay."

†Address: California Physicians' Service, 333 Pine Street, San Francisco. Telephone EXbrook 3211. Alson Kilgore, M.D., Secretary.

Copy for the California Physicians' Service department in the OFFICIAL JOURNAL is submitted by that organization.

For roster of nonprofit hospitalization associates in California, see in front advertising section on page 3, bottom left-hand column.

Plans for arranging the dinner next Monday evening are in charge of the committee on the plan for the Kern Medical Society and includes Dr. Louis Packard, Dr. William H. Moore and Dr. Carl I. Moore.—*Bakersfield Californian*, October 18, 1940.

* * *

Group to Talk Medical Service

Further steps toward bringing a large proportion of Santa Barbara's population within the scope of group medical service will be taken at a luncheon in El Paseo tomorrow.

The Health Conservation Committee of the Chamber of Commerce, with Dr. Neville T. Ussher as chairman, is endeavoring to arrange for attendance at the meeting of a representative group much enlarged from that which held a preliminary discussion last week.

Service clubs, civic organizations and business men are to take part in tomorrow's discussion of a city-wide campaign planned for mid-November. Questions pertaining to the services offered by the Associated Hospital Service of Southern California and the California Physicians' Service will be answered.

As now provided, the group medical plans are available to organized groups of thirty or more. It is the intention of the Chamber committee and other local sponsors to direct, during the forthcoming Health Week, a concerted effort toward forming such eligible groups and obtaining for them the benefits of low-cost hospital and medical service.—*Santa Barbara News Press*, October 16, 1940.

* * *

Stockton Doctor Talks to Rotarians on Medical Costs

The cost of medical care was the subject of an address given by Dr. Dewey Powell, Stockton physician, at a meeting of the Modesto Rotary Club in the Hotel Hughson yesterday.

"The problem of medical care is not a difficult one for the wealthy or for the poor," the speaker said, "but it is serious for the middle class families of America."

Discussing possible illness, Doctor Powell declared 47 per cent will not be ill during a year's time, 46 per cent will be sick one or two days and 7 per cent will be sick for more than three days. Of the last group, over 80 per cent will not be seriously affected.

"More than \$1,000,000 a day in services is donated to the public in free clinical work by physicians in this country," Doctor Powell stated.

In discussing the distribution of the medical dollar, the Rotary speaker said 30 cents goes to the physician, 24 cents to the hospital, 22 cents to the druggist, 14 cents to the dentist and 10 cents for miscellaneous expenditures.

Doctor Powell briefly discussed the California Physicians' Health and Hospital Service whereby medical care is provided for \$2.50 a month.

Dr. J. K. Morris was program chairman. Herbert G. Florcken presided at the meeting.—*Modesto Bee*, October 16, 1940.

* * *

"Insurance Association of Approved Hospitals" Changes Name

Now the "Hospital Service of California"

Byron F. Ashton, manager of the Insurance Association of Approved Hospitals, announced today the organization had changed its name to the Hospital Service of California.

Ashton also declared that the organization had moved its offices from the Easton Building to 364 Fourteenth Street as the result of an expanding membership.

The association was founded four years ago by the Alameda County Medical Society and since has grown until the present membership includes 37,000 persons from several Northern California counties. More than \$500,000 in hospital fees have been paid out since the organization began, Ashton said.

Ashton explained the change in name has met the approval of the Secretary of State and the State Insurance Commissioner. Dr. W. E. Mitchell is president of the organization.—*Oakland Tribune*, November 13, 1940.

COUNTY SOCIETIES†

CHANGES IN MEMBERSHIP

New Members (38)

Butte-Glenn County (1)

Harry E. Balch, *Stirling City*

†For roster of officers of component county medical societies, see page 4 in front advertising section.

Los Angeles County (21)

Edwin T. Bishop, *Los Angeles*
Benjamin Goldberg, *Los Angeles*
N. Edward Gourson, *Los Angeles*
Richard Stewart Harrison, *Pasadena*
Coleman B. Hendricks, *Los Angeles*
Milton R. Jones, *Claremont*
Arthur L. Kobal, *Los Angeles*
William Frederic Lynn, *Pasadena*
Katherine MacEachern, *Los Angeles*
Bernard John Mark, *Los Angeles*
Frank A. Moran, *Santa Monica*
Aidan A. Raney, *Los Angeles*
William George Rathmann, *Inglewood*
Nathaniel James Redpath, *Glendale*
James Francis Regan, *Los Angeles*
Sydney Nathaniel Soll, *Los Angeles*
Wendell Wallace Starr, *Los Angeles*
Charles C. Stehly, *Los Angeles*
Daniel Francis Sullivan, *Pasadena*
Henry Charles Ward, *Huntington Park*
Harold F. Ziprick, *Los Angeles*

Merced County (1)

Clyde G. Stuart, *Atwater*

Riverside County (1)

Walter J. Wood, *Corona*

San Francisco County (7)

George R. Baba, *San Francisco*
Jack Cohn, *San Francisco*
John William Fricke, *San Francisco*
Angel N. Gropper, *San Francisco*
Malcolm Jones, *San Francisco*
Angelo M. May, *San Francisco*
Edmund W. Overstreet, *San Francisco*

Santa Barbara County (1)

Harold James Suenaga, *Guadalupe*

Santa Cruz County (1)

John Dunphey, *Watsonville*

Ventura County (5)

Ernest R. V. Anderson, *Ventura*
Florence Olive Austin, *Ventura*
Everett C. Beach, *Oxnard*
Austin F. Daly, *Ventura*
Roger F. Scherb, *Camarillo*

Transfers (6)

Frank A. Brewer, from Solano County to Alameda County.

Orvin P. Fry, from San Joaquin County to Placer-Nevada-Sierra County.

Harry Edward Kaplan, from San Joaquin County to Los Angeles County.

Julius Lewis, from Sonoma County to Alameda County.

Robert Lewis, from Sonoma County to Alameda County.

N. John Zahry, from Inyo-Mono County to Los Angeles County.

In Memoriam

Adams, Lemuel Payson. Died at Richmond Island Gun Club, Suisun Bay, October 27, 1940, age 64. Graduate of University of Vermont College of Medicine, Burlington, Vermont, 1899. Licensed in California in 1900. Doctor Adams was a member of the Alameda County Medical

Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Berkes, Harvey Alfred. Died at Hollywood, October 30, 1940, age 58. Graduate of Western Reserve University School of Medicine, Cleveland, Ohio, 1909. Licensed in California in 1922. Doctor Berkes was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Brown, Philip King. Died at San Francisco, October 28, 1940, age 71. Graduate of Harvard University Medical School, Boston, Massachusetts, 1893, and licensed in California the same year. Doctor Brown was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Brush, Nathaniel Hawley. Died at Santa Barbara, October 21, 1940, age 53. Graduate of Johns Hopkins University School of Medicine, Baltimore, Maryland, 1914. Licensed in California in 1920. Doctor Brush was a member of the Santa Barbara County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Deane, Louis Charles. Died at San Francisco, October 17, 1940, age 70. Graduate of Cooper Medical College, San Francisco, 1891. Licensed in California in 1895. Doctor Deane was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

✦

Leviton, Henry Isaac. Died at Los Angeles, November 11, 1940, age 54. Graduate of University of Illinois College of Medicine, Chicago, Illinois, 1909. Licensed in California in 1920. Doctor Leviton was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Skeel, Donald Wallace. Died at Los Angeles, October 11, 1940, age 67. Graduate of University of Southern California School of Medicine, Los Angeles, 1899. Licensed in California in 1900. Doctor Skeel was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✦

Tupper, Roland Beatty. Died at Fresno, October 30, 1940, age 54. Graduate of Cooper Medical College, San Francisco, 1910, and was licensed in the same year. Doctor Tupper was a member of the Fresno County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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OBITUARIES*

Lemuel Payson Adams 1875-1940

To your committee has been assigned the distinguished privilege of setting down, and presenting to this organization a few facts to do honor to the name of one who, for many years, lived in this county, partaking of its civic, its professional and its social life, signally adorning each.



Only in a minor sense biographical, it is an attempt at an appraisal of the character of a man by three of his fellows who knew him well—knew his quiet courage and that intellectual honesty which we call sincerity.

A great English clinician many years ago declared: "Show me the houses in which people live and I will estimate their health." By analogy, thought given to the background of inheritance and environment of an individual does sometimes enable us to appreciate the formation and significance of his character.

The Adams family, from which Lemuel derived his heritage, is an old one in the history of America. Their American annals began in Massachusetts in about 1628, whence, several generations ago, they heard the call of a new land and made their adventurous way to Vermont. There the family took root and became active participants in the affairs of another pioneer commonwealth.

The Green Mountains and the Adirondacks were within the circle of their eyes. Surrounded by that aura of romance and history, they worked out their destiny, the influence of which has touched so many lives in California.

In 1875 Lemuel Adams was born in Vermont. In Vermont he was educated, receiving both his scholastic and his professional degrees at the State University, of which he was later a trustee.

That University merits some comment. Toward the end of the eighteenth century the University of Vermont was founded by a gift from the brother of Ethan Allen, known to every American schoolboy as the hero of Fort Ticonderoga. It was built at Burlington, on the east shore of Lake Champlain, whence every student could drink in the beauties of the two mountain ranges whose traditions stir the hearts of the sons and daughters of America.

When Doctor Lem was graduated in medicine, six-sevenths of the population of Vermont were native-born. Most of the other one-seventh were Canadians: French or British. Of the farms—and they exceeded 30,000—more than five-sixths were farmed by owners.

Such were the remote ancestry and the immediate environment of this Adams family of Vermont. Now, for nearly three-quarters of a century rooted in California, it has contributed largely to our own community life.

We are not aware of the specific impulse which took Lemuel into medicine. One uncle, John S. and his son, Frank—both doctors and both of blessed memory to Oaklanders—together with another uncle, engaged in the practice of medicine, elsewhere, certainly must have offered great inspiration to a young relative planning his life work.

John Adams, after graduating from Albany Medical College in 1855, practiced for a time in that city where his son, Frank, was born. Soon new lands beckoned westward and he obeyed, even as his forebears had done.

* For editorial comment, see page 256.

The trek across the plains to California was made in 1865. He practiced in the Mother Lode country for a time and then removed to St. Helena, where his little office still stands. But the Bay area called and, before long, John Adams moved to Oakland and embarked upon the final and most notable phase of his career in medicine. Active in his purely professional work, he was, yet, able to assume his share of civic responsibility and to take an active interest in the affairs of this Medical Association, of which he was a member from 1871 until his death in 1899.

Frank L. Adams, educated in the Oakland schools and the University of California, received his degree in medicine from Cooper Medical College in 1885. After completing his internship at the City and County Hospital in San Francisco, Frank was associated with his father, sharing alike his medical enthusiasm and his civic consciousness. He was one of the founders of the Oakland College of Medicine and Surgery, the alma mater of several of our notable colleagues, some in this audience. Frank L. Adams was president of the State Medical Association (Medical Society of the State of California) in 1904.

John Adams had come to California before Lemuel was born. However, he had built and maintained a vacation cabin on Lake Champlain and made many excursions from California to Vermont to enjoy it. He was something of a patriarch to the Adams clan. They rallied about him when Vermont called him home for rest and recreation. No chap of Lemuel's type could remain indifferent to such stimuli as must have radiated from this most attractive personality, this doctor from far off California—his own uncle.

But at home there was another personality of great moment to this youth. An ancient philosopher emphasized the fact that one could have a good neighbor only by being one. The Adams family had a good neighbor—one Doctor Allen, the family physician. Allen was a graduate of McGill. He was widely read, an enthusiastic student, a visitor to clinics at home and abroad, well informed in the knowledge of the practice of medicine of his time. He was greatly attracted by the quiet, intelligent son of his good neighbor. Lemuel, then in high school, spent spare or allotted time in Doctor Allen's office, rode with him on his calls and was of assistance to him, on occasion, in minor surgery.

It was common, in an earlier day, for one who was contemplating the study of medicine to place himself under the guidance of an established physician in order that he might become familiar with some of the working details of the healing art. Such physicians taught by precept, but not by precept alone. To Lemuel came the inestimable privilege of a guidance which revealed to him something of the flavor, the rhythm, the privilege, the sacrifice, and the self-abnegation involved in one of man's jobs for man—the practice of medicine. Well might the young student have said in reminiscence of Doctor Allen:

"Thy learned precepts called me back and set my footings straight."

Preceptors are no longer in fashion. Except in scattered instances, they have gone out of style. But so many men have taken inspiration and understanding from time spent with elder minds in medicine that some schools are still making the experiment of assigning students to the homes of selected general practitioners for stated periods. In such homes and in such professional association the fortunate candidates are made somewhat familiar, first hand, with the intimate traditions of the art of medicine, something of its science, and more of its human kindness.

In 1899 Doctor Lem had graduated. Then followed his internship in the Boston City Hospital, followed by one in the Lying-In, in New York. John Adams' well-rounded life had ended. Frank, in Oakland, was ready for a junior assistant. So the third representative of the Adams family came among us to create his own niche in 1901.

This niche—as events proved—must needs be of large dimension. First came membership in County, State, and American Medical Association. Then ensued a steady succession of honors: professor of anatomy and, later, of surgery at the Oakland College; president of the Alameda County Medical Association; chief of Surgical Division of the old Alameda County Hospital and, until his death, of the east wing of the new one; captain of the Medical Corps, United States Army, in the Great War; fellow of the American College of Surgeons; licentiate of the American Board of Surgery; a founder of the American Association of Traumatic Surgery; member of the California Academy of Medicine and of the Pacific Surgical Association. Doctor Adams rendered important service to medicine in California as member of the Committee on Scientific Work of the California Medical Association and as chairman of the Board of Trustees of the Indemnity Defense Fund. All of these honors were badges of recognition and not products of the chase. But among the honors in the niche the greatest space of all was required for Lemuel Adams—beloved physician.

With all of these activities he took ample time for the amenities of friendship and recreation. His practice, like that of most of us, was among all walks of life. He knew "The huts where poor men lie, and the chores that poor men do." But wherever he found himself he had the power to make his talent trusted.

In the best tradition of American medicine he was active in keeping his profession free from taint within and resistant to the efforts of disturbing influences of whatever sort from without. In all things conservative he was, nevertheless, able to foresee the changing trends in medicine and those of economic life and meet them directly and intelligently. "Intellectual and emotional sanity and integrity, from which wisdom, kindness, and courtesy are derived," were his natural endowments.

There must have been really great similarity in the lives and characters of the three departed Adamases known to us. John S. was noted as "One of the men who are landmarks of the development of the race—rugged, stern, and uncompromising where a principle is involved." Frank was described as "Courageous, generous, kind, of inflexible integrity, profound learning, and eminence in his profession."

Osler could very well have had these three in mind when he wrote, "Great men in medicine have influenced their profession less by their special work than by exemplifying those graces of life and refinements of heart which make up character." Each of the three Adamases who have labored among us was one of the eminent doctors equal to his office.

On the morning of October 27, while on a duck-shooting expedition, Lemuel Adams died from a sudden heart attack. In the evening of his life, engaged in the recreation which he loved, surrounded by the golden glory of breaking day, he sat in his duck blind. Then the black camel that sooner or later kneels in front of every man's door knelt out there on the marsh for him. Death laid a quiet hand upon his brow and he slept even as he might have wished.

Let no man declare that we come into this life empty-handed and leave it so. We come with whatever heritage our forebears transmit. The attributes of the parents are in the brood. You know Stevenson wrote, "I am bound in and in with my forebears."

We begin life with that heritage. We multiply our talents or not as the case may be. Leaving it, a reputation, good or indifferent or evil, accompanies us. Intelligence, honesty, the spirit of human kindness, steadfastness in the face of his own problems and in meeting the needs of those requiring his help—these attributes commanded the abundance of affection and respect that accompanied Lemuel Adams as he left us.

If the ultimate hope of a man's career is to find a faith in some aspect of life which offers him happiness in constructive employment, then the life of this doctor of medicine, our colleague and friend, was one of complete fulfillment.

We salute the son of Dr. Lemuel Adams, another Doctor John, and congratulate him upon his heritage, aware that the Adams tradition is safe in his keeping.

EDWARD N. EWER

WILLIAM H. STRIETMANN

DANIEL CROSBY

Committee.



Philip King Brown

1869-1940

The passing of Philip King Brown removes from the medical profession of California one of its most notable members. A man of high character, philanthropic disposition, a scholar of great attainment, a citizen whose self-sacrifice and services to the community were many and invaluable, a gentleman in every sense of the word. Dr. Philip Brown was one of a family that has made medical history in California. His mother, Charlotte Blake Brown, founded the Children's Hospital and training school for nurses, pioneering in the field of medical education for women in the medical nursing fields. Her children, Adelaide Brown and Philip King Brown, carried on from where Charlotte Brown stopped when she laid down the burden of life.

Philip King Brown's unselfish interest in sick and suffering humanity was apparent to everyone in California, for everyone knew him personally or by reputation. This interest led him to organize and found Arequipa Sanatorium in 1911. This institution was designed to aid young working women who had become tuberculous to overcome their tuberculosis and attain rehabilitation. Through this work of Philip King Brown at Arequipa, many scores of working girls and mothers have been restored to health and the possibility of earning their own way once more or again caring for their families. Doctor Brown was the medical director at Arequipa for seventeen years and has been secretary of its board of directors for the past fourteen. As further evidence of Doctor Brown's social-mindedness may be cited his part in organizing the San Francisco Boys' Club, of which he was one of the first directors. Doctor Brown's independence of mind and vigorous interest in medicine led him to take a position in the matter of compulsory health insurance, decidedly in conflict with ideas held by the majority of his colleagues. But because of the honest and vigorous way in which he

presented his views, he held the respect of those who differed with him and the affection of many.

Doctor Brown was deeply concerned with medical education and at various times held positions as a teacher at the University of California Medical School and at Stanford University Medical School. He was also, for many years, supervisor of the medical service at the Southern Pacific Hospital and from this vantage position contributed greatly to advance the character of medical education given to the house officer staff of that hospital, and at the same time he contributed much to help bring the services given to patients at that hospital up to their present very high standard. Using his hospital material, he became an able and widely read medical author, contributing largely in the fields of public health, social welfare, health insurance, and clinical medicine and pathology. Together with Dr. W. B. Coffey and Dr. J. B. Humber, he produced a monograph on angina pectoris.

Happily, Doctor Brown won ample recognition from his fellows, as is evidenced by the many societies to which he was admitted and the numerous committees on which he held appointments; among these were the Physicians' Committee for the Improvement of Medical Care, the Committee on the Cost of Medical Care, the Interdepartmental Committee to Coördinate Health and Welfare Activities. He was a member of the American Medical Association, the California State Medical Society, the California Academy of Medicine, the Association of American Physicians, and many other medical and surgical societies, among them the American Association of Industrial Physicians and Surgeons and the national and local Tuberculosis Associations. His American lineage is attested by his hereditary membership in the Society of Colonial Wars and the Society of American Wars. He was an active member of the Commonwealth Club of California and he acted in 1918 as an adviser to the Department of Intelligence and Research of the Red Cross in Europe. He was graduated from Harvard, A.B. 1890, M.D. 1893. He spent the years 1895 and 1896 in Germany doing post-graduate work in medicine at Berlin and Göttingen and spent some time of both those years in Paris and London. The writer recalls very vividly that while he was an intern in the local hospital in 1897, whenever a clinical problem difficult to solve was brought up some senior member of the staff would say: "Phil Brown will be back before very long. Let's keep that one for him; he'll know about it."

Doctor Brown is survived by his widow, Helen Adelaide, to whom he was married in March, 1900, and by four children, Hillyer, Bruce, Cabot, and Phoebe. Cabot carries on the family tradition in medicine.

The medical profession of California will be poorer through the loss of Philip King Brown. His independent point of view, his uncompromising character and vigorous presentation of his beliefs and convictions, will be missed sorely in the councils of his colleagues; but his kindly ministrations, his human feeling and his great professional skill will be even more a loss to the sick and suffering in the wards, clinics, and sick rooms accustomed to his gracious presence.

LANGLEY PORTER, M.D.



Guy Hunt Cochran

1873-1940

After an intimate association and friendship with Guy Cochran for over a quarter of a century, there are a great many accomplishments and historical data that might be recorded of him.

His birth and environment: The only son of one of California's pioneer physicians. His every advantage from this parentage related to training and education. His physical and mental superiority, which made him outstanding in collegiate and after life. His thorough and classical edu-



cation. His skill as a surgeon and his successful application of this skill in a long life of usefulness in the healing art. The many positions of trust and honor held. His military service to his country. His never-failing efforts in our various charity institutions.

But to me there is one trait of "Guy's" character which, in spite of all the honors and successes, is predominant and stands out and will continue after all others are forgotten—his friendliness.

No matter what his surgical skill did to his patients, the grip of that great, soft hand, along with that winning smile, did more. He was always friendly, always courteous to the extent that you simply could not quarrel with him. His relation to his friends was credulous and filled with almost childlike optimism. He viewed the world with some lack of deep thought, but with strong, intelligent feeling. This friendliness, of course, made friends, for in giving it the returns were inevitable.

The memory of his smiling, friendly character will linger and soften the loss of his passing.

PHILIP STEPHENS.

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Nathaniel H. Brush

1887-1940

Only an extended review of Doctor Brush's activities during the past twenty-six years would give a fair idea of what his passing means to American psychiatry. He was not merely one more member or fellow in such scientific societies as the American Psychiatric Association, the American Board of Psychiatry and Neurology, the National Committee for Mental Hygiene, and state and county affiliates of the American Medical Association: as the years passed the officers and members of these national organizations turned to him with ever-increasing confidence in his ability to help define their policies and to further the good cause for which they stood. His passing will evoke many well-earned tributes to his memory from colleagues who think of him as a national figure in his specialty of medicine. These will be a source of pride to those of us who worked with him as fellow physicians in Santa Barbara.

No formal record of Doctor Brush's achievements as a physician can adequately imply the tribute some of us wish

to pay him as the man we knew. It was my privilege to come very close to him as a colleague in the same specialty. This relationship disclosed traits of character which are rare, even in high-principled, "ethical" physicians. Unselfishness was the foremost of these. Outsiders may have thought of us as competitors, but Doctor Brush never made it possible for either of us to feel that we were. There were many times when my disadvantage would have been an immediate advantage to him, but he never stood by, silent and inactive, when he saw a chance to spare me such disadvantage.

He suffered a vast amount of physical pain from time to time all through his professional life, but he had the kind of courage that enabled him to hide it when men of less fortitude would have crumpled in self-pity. He possessed courage of another sort which, perhaps, only a fellow psychiatrist could fully appreciate. It was his willingness to incur the anger and even long-continued, persecutory hostility of prominent citizens and their families by demanding the hospitalization of persons whom he knew to be mentally ill enough to be a menace to themselves or others. I have known him to sacrifice large fees and local prestige as a psychiatrist by making and sticking to a diagnosis which meant commitment to an institution of a patient whose relatives refused to admit the existence of a dangerous mental illness. The future psychiatrists who came under his tuition when he was on the staff of the Phipps Psychiatric Clinic of Johns Hopkins Hospital were lucky to have such a teacher.

It is natural for one to exaggerate the virtues of a friend while the grief caused by his loss is still acute, but these tributes to his memory are only repetitions of what I have had occasion to say about him many times during the past decade. Even when he was in good health, I felt that it was a meager return of his generosity to say of him to others, as I often did, "He is the most unselfish colleague I have ever known."

G. V. HAMILTON.

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Roland Beatty Tupper

1886-1940

Doctor Tupper died on October 30, 1940, at the Burnett Sanitarium, Fresno, his death being due to an occlusion of the coronary artery. Doctor Tupper was born in Fresno, July 26, 1886, and after his preliminary education, entered Cooper Medical College, from which he was graduated in 1910. His internship was served at St. Luke's Hospital and later he was on the diagnostic staff of that institution. He served as clinical professor of medicine at Stanford Medical College while a resident of San Francisco. During the World War, Doctor Tupper went to Europe as a member of the Stanford group and was stationed in Scotland, at the United States Navy Base Hospital. Returning to San Francisco in 1919, Doctor Tupper entered private practice, associating himself with prominent San Francisco physicians and renewed his interest in his alma mater.

Owing to his great love for the wide open spaces—the mountains, the streams, and the forests—Doctor Tupper was persuaded to move to Fresno and entered practice in his birthplace. He built himself a large practice in Fresno, and was a frequent consultant in many diagnostic problems that presented themselves over a wide area of the San Joaquin Valley. He had had a large basic training and this, together with the fact that he was a devoted student, gave him a deep knowledge of medicine. In Fresno he became associated with the Burnett Sanitarium and was made chief of staff, internal medicine, at the Fresno General Hospital, which position he held until his death. Doctor Tupper was a stickler for ethics and practiced medicine on a high ethical and moral plane. He was respected by the entire profession for his ethical conduct toward others and for his profound diagnostic acumen.

Doctor Tupper's death came as a distinct shock to the profession and to our community. He went to bed on the night of Friday, October 18, and during the early morning hours was seized with dyspnea and pain. He was taken to the Burnett Sanitarium, but never rallied and death occurred, as stated, on October 30.



Louis Charles Deane

1870-1940

On October 17, 1940, our society lost a member of long standing in the death of Dr. Louis C. Deane. Born in San Francisco, Doctor Deane attended the University of California, Cooper Medical College, and Stanford University, and received his M. D. from the École de Médecine in Paris in 1894. Specializing in diseases of the eye, ear, nose, and throat, Doctor Deane acted as chief of staff in ophthalmology at Mount Zion Hospital in San Francisco from 1912 to 1926, and for the last twelve years has been a visiting surgeon at Stanford Hospital in this city.

Doctor Deane was an enthusiastic golfer and mountain climber, and lover of other outdoor sports. He belonged to the Bohemian, Olympic, and Presidio Country Clubs. He was the author of many scientific monographs on his specialty.

The sympathy of the Society has been extended to Mrs. Deane in her bereavement.

H. M. F. BEHNEMANN.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. A. E. ANDERSON.....President
MRS. WILLIAM C. BOECK.....Chairman on Publicity
MRS. KARL O. VON HAGEN..Asst. Chairman on Publicity

An interesting account of the work of the County Physiotherapy Department was given by Mrs. Ruth O'Dell at the October meeting of the Humboldt County Auxiliary.



Fresno County entertained State President Mrs. A. E. Anderson on November 6 at the Californian Hotel. The members heard an appropriate talk on *Medicine in a National Emergency*, by Dr. Henry Randel.



Seventy-five members and guests of the Los Angeles County Auxiliary were entertained by Dr. J. Whitcomb Brouger, pastor of the First Baptist Church in Glendale. Mr. S. K. Cochems requested the group to assist in publicizing the Los Angeles National Health Defense Exposition to be held on February 2 to 10, 1941. The opening of the Auxiliary's unit of the Red Cross on November 6 at the Hollywood Hospital and a call for surplus surgical instruments for the British War Relief were announced by the president, Mrs. Ralph B. Eusden.



The Monterey membership entertained Mrs. Anderson at a musical tea on September 20. The regular monthly

†As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Karl O. Von Hagen, Assistant Chairman on Publicity, 2435 Nottingham Avenue, Los Angeles. Address of the Chairman on Publicity: Mrs. William C. Boeck, 712 North Maple Drive, Beverly Hills.

For roster of officers of state and county auxiliaries, see advertising page 6.

meeting was held on October 3 at the Forest Lodge in Carmel. Mrs. Spencer Hoyt, *Hygeia* chairman, was the principal speaker.

On October 2, Mrs. George A. Briggs, President, entertained the Sacramento Auxiliary at tea in her home. The group sponsored the reading of Massenet's opera, "Manon," before a large audience in the Hotel Senator.



The San Diego group inaugurated those "Medical Information, Please" meetings on October 28, modeled after the famous radio program. A group, composed of three specialists and a questioner, discussed briefly, in non-technical terms, questions in which the layman would be interested. This first meeting was held before a group of Girl Scout leaders. Following the planned program, an audience of some fifty or sixty persons was given an opportunity to question the experts.



Dr. R. C. Kneeshaw discussed *Socialized Medicine* before the Santa Cruz Auxiliary on October 28. Some twenty-five members and guests attended the luncheon at the Pasatiempo Country Club. The same group is planning bridge parties, both in Santa Cruz and Watsonville, the proceeds of which will be donated for treatment of children with impaired hearing in the district public school.

CALIFORNIA TUBERCULOSIS ASSOCIATION†

1940 Christmas Seal Sale

TUBERCULOSIS AND RACIAL GROUPS

The expanding and rapidly developing program of the tuberculosis associations of California owes much of its effectiveness to the work of the physicians of the state. It was under the guidance and with the untiring assistance of the large group of doctors who are active in the associations that the testing and x-raying of school children was carried out during the past few years. In this program more than 300,000 children have been examined to discover infection. The school program did not stop there; but with the help of doctors and nurses the follow-up work has gone forward so that every home from which the positive reactors came has been visited and adults examined.

Active, too, in the work of carrying on the educational activities, both in school groups and in adult groups, physicians of the state have done yeoman service. Case-finding and education on how tuberculosis develops, how it spreads, how it is treated, and the emphasis on the responsibility of the individual in keeping his community health standard high have all been carried on in such relationship and in such close coöperation with all community groups that the whole tuberculosis program has become an integral part of community life.

Because our school children form a naturally regimented group, schools were the logical place to start a coördinated case-finding and health education work. This kind of program is now being carried forward in every county of the state.

Doublin suggests that a productive field for mass survey to discover hidden cases of tuberculosis is that of the racial groups. The incidence of tuberculosis in Chinese, Japanese, Negro, and Mexican groups is inordinately high. These people need a planned health education program; procedure for mass surveys needs to be formulated; follow-up programs to find the sources of infection are called for.

† From California Tuberculosis Association, W. F. Higby, Executive Secretary, 45 Second Street, San Francisco.

A beginning on such a program has already been made in the state and these projects will be strengthened during the coming year.

Mexicans, with a California population of 446,000, had, in 1939, 785 deaths from tuberculosis, a death rate of 176, or 20 per cent of all the tuberculosis deaths. Control measures specially designed to find cases among Mexicans have been successfully applied in Orange County, Kern County, Santa Barbara County, and certain areas in Los Angeles County. Such programs are now urgently needed in other counties in the southern part of the state.

Negroes, with a population of approximately 100,000, had 196 deaths last year. The greatest concentration of Negroes is in Los Angeles, and for the past three years the Los Angeles Tuberculosis Association and the County Health Department have been coöperating in a program for Negroes which has gained national notice. The second largest concentration of Negroes is in Alameda County, and plans are now completed for concerted effort to improve the conditions in that county.

The Chinese, with a population of 45,200, largely in San Francisco, had seventy-two deaths from tuberculosis in 1939. During the past year, the San Francisco Tuberculosis Association has examined 3,000 Chinese and expects to complete the examination of 2,000 more before the end of the year. Due, in great part, to the educational work done among Chinese, their death rate from tuberculosis is decreasing.

The Japanese have established a record in that the decrease of the death rate from tuberculosis is greater among them than among the general population. There are approximately 118,000 Japanese in California and the death rate last year was 65 per 100,000. They are coöperating quite generally with tuberculosis associations throughout the state in the education of their own racial group.

While emphasis will not be shifted from the school health program as it has been established, it is expected that the program among racial groups will be enlarged during the coming year.

ANNUAL COUNTY MEDICAL SOCIETY REPORTS†

FIRST DISTRICT

Imperial, Orange, Riverside, San Bernardino, and San Diego Counties; Calvert L. Emmons, Ontario, Councilor.

Imperial County Medical Society

The Society has twenty-one active members; one new member during the year, and at the present time one application on file. Two members were lost by withdrawal, and one by transfer to the Los Angeles County Society. At present there are two or three physicians who have not completed the required length of residence in the county.

Our meetings are held in El Centro, at the Barbara Worth Hotel, as a dinner meeting at 7 p. m. on the third Tuesday of each month, except July, August, and September. Usually a guest speaker is obtained, and on many occasions motion pictures are used to illustrate the papers. Joint meetings have not, to my knowledge, been held with other groups nor have we held any meetings open to the public.

Imperial County has recently elected a new State Senator, E. George Luckey, who resides in the city of Brawley, and who believes in proper public health activities.

CLAUDE F. PETERS,
Secretary.

Orange County Medical Association

The Orange County Medical Association consists of 124 active members. During the past year we have lost two members by transfer and have had one member reinstated; and we have welcomed into the Association eight new members. The Society keenly felt the loss of two very loyal and capable members in the death of Dr. D. C. Cowles and Dr. A. H. Domann.

* For editorial comment, see page 254.

County societies are arranged alphabetically, under their respective districts.

The Association meets on the second Tuesday of each month, and has five dinner gatherings. We find this type of meeting most attractive in bringing out the membership, which has always steadily increased. We consider ourselves very fortunate in Orange County in being so near to Los Angeles, as we have been able to bring out to each meeting—under the leadership of our very capable program chairman, Dr. Milo K. Tedstrom—men who are outstanding specialists in their line. During the year we have discussed the following subjects: Thyroid Disorders; Diarrheas of Children and Adults; Treatment of Certain Types of Cancer of the Bladder by X-ray Therapy; Medical Aspects of Gastric Ulcer and Surgical Procedure; Syphilis; Toxemias of Pregnancy and Cesarean Section; and Peptic Ulcers.

For the past two years the Orange County Medical Association has joined the Public Health League 100 per cent. We feel that it is paramount that we support this worthy organization, which is the guardian of our political privileges and rights.

On January 25, we had a tri-county postgraduate meeting at the Ebell Club in Santa Ana, and this all-day program was well attended. Many worth-while subjects were discussed.

GLENN CURTIS,
Secretary.

Riverside County Medical Society

The Riverside County Medical Society, composed of seventy-seven members, has had its usual monthly meetings for nine months in the year. Two or three of these meetings have been largely of a social nature, including a visit of the officers of the California Medical Association. This latter meeting was held in conjunction with the San Bernardino Society at San Bernardino.

A postgraduate meeting was held at Riverside in the spring, when we were joined by the Orange and San Bernardino Society members, while we, in turn, later attended their meetings.

The Woman's Auxiliary meetings are usually held at the same time as those of the County Medical Society. The ladies generally hold their meeting at some home, the two bodies joining afterward in the evening.

We have an excellent library of current magazines kept at the Riverside Community Hospital. A number of the representative magazines are bound, and these files are complete since 1933.

PHILIP CORR,
Secretary.

San Bernardino County Medical Society

The San Bernardino County Medical Society has a membership of 156 active members and two on the retired list. During the year we gained eight new members, one of which was by transfer. We lost four members, two by death, one by transfer to another society, and one by resignation.

Our meetings are held monthly, October to June, both inclusive. The annual meeting, held early in October, was a dinner meeting, to which wives of our members and many other guests were invited. In February we joined with the Riverside County Society at the postgraduate meeting, and in March another postgraduate meeting was held in San Bernardino, in which the societies of Riverside and Santa Ana Counties joined. In April the Society was the guest of the staff of the Loma Linda Hospital and Sanitarium at Loma Linda. Dinner was served and a most enjoyable program followed. In June the Society was invited to the Patton State Hospital for dinner, and a very interesting program was arranged by the staff of that institution.

The other meetings were held at the San Bernardino County Charity Hospital, with speakers, in the main, from other cities. One of the outstanding programs of the year was that of February, at which Karl F. Meyer, Director of the George Williams Hooper Foundation for Medical Research, was our guest speaker. His subject was "Undulant Fever," and he was most enthusiastically received by those present.

Our Bulletin, through paid advertisements, is self-supporting, and is published monthly for nine months of the year, October through June. Notices of our meetings are given through this medium.

ARTHUR E. VARDEN,
Secretary.

San Diego County Medical Society

The San Diego County Medical Society will have had ten general meetings during the 1940 calendar year. That means that we meet once every month, with the exception of July and August, which are the vacation months, and no meetings are held unless something special occurs, at

which time the President calls a general meeting of the Society.

Up to November 1, we have 289 paid-up active members. There will be four admissions to the Society the latter part of November. There are twenty-one applications pending at the present time. Most of these applicants will be admitted to active membership. We have lost very few members through death this year. This speaks well for the health of our membership and the invigorating climate of San Diego and vicinity. However, we have lost eight members during the past month, called into active military service. How many more will be called is anyone's guess at the present time.

The California Board of Medical Examiners directory, issued March, 1940, indicates that there are 493 doctors of medicine licensed in San Diego County. No doubt additions have been made since March of this year when the directory was printed. The number of cultists practicing their trade in San Diego County are too numerous to mention. This seems to be a "landing field" for all new schemes, each year a crazier fad being born from another.

The San Diego County Medical Society has no regular group rooms or home of its own. Most of the meetings are held in the University Club, which has ample facilities for meetings and paraphernalia for lanterns, motion-picture apparatus and screens for the use of speakers. There has been a committee appointed to investigate the advisability of providing a permanent home for the Society and the library. It may be stated here that the financial condition of the San Diego County Medical Society at the present time is in excellent circumstances. We have rehabilitated the files of the library, a new addressograph purchased, and numerous additions during this calendar year were made.

The Bulletin of the San Diego County Medical Society comes out twice monthly. The advertisements practically pay for the expenses, with a slight profit to the Society. However, the business manager spends a great deal of time in obtaining advertisements, which are not taken at random, from any person who desires to advertise in the Bulletin. The editor and business manager give of their time, energy, and resources gratuitously. The time will come when other arrangements will have to be made, because it is unfair to expect practicing physicians to devote the time necessary to perform this work. A great deal more could be made through this source in the future, it is believed, by employing either a business manager or an executive secretary. The Bulletin has grown considerably during the past decade and, of course, the Society has grown along with it, too. The publication is no longer a one-man leaflet. The editor is calling for help and trained material is not sufficient, or it is being kept under cover, to give the editor the kind of help he desires on a gratuity basis.

According to my last report to your publication, I commented on the postgraduate activities of the San Diego County Medical Society. It seems that we are beginning to get some results with this type of instruction to the general practitioner. The present committee has been working hard all the year, and has sent out questionnaires which have been tabulated as to what kind of work the cross-section of the Medical Society really desires. This has entailed some expense, but it has been worth the effort. I am sure that this work through the Postgraduate Committee will become better organized and of increased benefit to the general practitioner. We are having a postgraduate course on November 20, 1940, which is the second one this fall.

The California Public Health League has been very active and alert this year. It has succeeded in helping to elect two fine assemblymen to the State Legislature. These two have always cooperated with organized medicine perfectly, and no doubt will continue to do so. An excellent public policy has been established by the professional groups locally—that is, the physicians, dentists, nurses, druggists, and the County Board of Supervisors. It is hoped that this fine relation will continue.

There are many more subjects which I could write to you about in this report, but I know that reports can become burdensome if too lengthy, and will defeat the very purpose for which they were intended. With this in mind, I want to thank you for the cooperation and helpful suggestions I have received from you during the past several years.

C. V. BERNARDINI,



Secretary.

SECOND DISTRICT

Los Angeles, Inyo, and Mono Counties; George D. Maner, Los Angeles, Councilor.

Inyo-Mono County Medical Society

The Inyo-Mono County Medical Society has had a very successful year, and cooperation among all our doctors has

been excellent. The distances traveled to attend meetings speaks well for the member interest.

Probably the highlight of the year was the visit of Doctors Packard and Kress with other doctors, who presented a very interesting scientific discussion of current problems. Another meeting that went into tick infections was also stimulating, especially as two cases of relapsing fever have been reported from this district.

Dr. William Russell was over to the Coast for an examination, and there is a possibility he may be called up, as he is a Naval Reserve officer. It would be a loss to our Society and to Mono County (where he is the only doctor) were he called upon to leave civil practice.

At our November meeting, new officers for the coming year will be elected. They will begin plans for 1941, when we meet again in March. Until then our meetings are suspended.

C. L. SCOTT,

Secretary.

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Los Angeles County Medical Association

The Los Angeles County Medical Association has enjoyed a healthy growth in membership during the past year, 132 new members being admitted since January 1.

Active membership of the Association today is 2,598; changes in membership status are as follows: Deceased members, 29; retired members, 16; resigned, 8; transferred, 9; on leave of absence, 34; dropped from membership, 31.

General meetings of the Association have been as follows:

January 4—A program presented by the California Physicians' Service and the election of Association officers.

January 18—A Program presented by the Research Study Club.

February 1—A program presented by the Medical Symposium Society.

February 15—A talking motion picture on "Syphilis."

March 5—A general meeting, arranged by the Eye and Ear, and Urological Sections.

April 12—Los Angeles Surgical Society and the Western Branch of the Orthopedic Association presented a program.

April 18—An open forum on "The Press and Medicine."

May 16—Conjoint meeting with the First District Dental Society.

September 19—"The Medical and Religious Rights of the American Citizen Under Increasing Government Control," participated in by representatives of the various faiths.

October 19—"The Clinical Importance of Vitamin B Complex," presented by Dwight L. Wilbur, M. D.

November 7—Symposium on "Military Preparedness"; a program presented by the Junior Section.

The December general meeting will be devoted to the problem of malpractice insurance.

One of the most interesting meetings of the year was the open forum on "Press and Medicine." This was an extemporaneous presentation in which three members of the Association met a round-table discussion with three representatives of the Press. The result of this meeting was a clarification of many of the problems relative to the attitude of the Press toward Medicine, and the attitude of many members of the profession toward the Press.

The Los Angeles County Medical Association for the past six years has enjoyed the facilities of its own quarters, including one of the best-equipped medical libraries west of the Mississippi River. Indebtedness on these buildings and equipment was paid off before the beginning of this year.

The official publication of the Association—the *Bulletin of the Los Angeles County Medical Association*—has enjoyed a considerable increase in revenue from advertising during the past six months. This has offered the editor an opportunity to increase the reading matter in the publication, allowing for the use of pictures to stimulate its reader interest. The gross revenue from advertising in the *Bulletin* for the year 1940 should be approximately \$20,000.

All committees of the Association have been active during the year, but special mention must be given to the activities of the following committees:

The Committee on Public Policy and Relations, for carrying on an extensive health education program through the Speakers' Bureau, which sends speakers to many lay organizations throughout the year.

The Committee on Certified Milk Production and Distribution for the supervision of the production of certified milk in this county, resulting in an enviable record of purity and cooperation on the part of the certified dairies.

The Committees on Professional Conduct and Fees have done much to encourage better understanding between the members of the profession and between the members of the profession and patients.

The Committee on Scientific Work and Programs, aside from presenting to the Association a number of interesting general meeting programs, has worked with the various sections in the making of the plans for a public health

exhibition, to be sponsored by the Association, in February of 1941.

The Committee on the Library is constantly working to improve the facilities of the library so that these may be available to all members of the Association, regardless of their place of practice in the county.

The Committee on Relief and Fraternal Relations caused the creation of a Los Angeles County Physicians' Aid Association, now functioning to give relief to a number of doctors and their families who are in need of this assistance.

The Woman's Auxiliary has been extremely cooperative in all activities of the Association, especially in connection with the arranging of talks on medical subjects to be presented by members of the Speakers' Bureau.

For the past four years the Speakers' Bureau of the Association has performed a far-reaching service in public education. On the Speakers' Bureau, available for the presentation of talks on any subject pertaining to medicine, are approximately one hundred members, well qualified as public speakers. During the fall, winter, and spring seasons, calls for speakers are received practically every day. One activity of the Speakers' Bureau is the presentation of medical talks at the Public Library each month.

The Committee on Public Policy and Relations, with the sanction of the Council, is now setting up a Press Information Bureau. This information bureau shall consist of a rotating list of doctors of medicine, representing all the specialties. The members of this bureau have the authority of the Association to be quoted as "speaking for the Los Angeles County Medical Association" when interviewed by the press. The various newspapers of the county will be presented with a roster of the members of this information bureau.

The Association is completing its tenth year of weekly radio broadcasts which, for nine years, have been prepared and presented by its executive secretary.

The major public relations activity of the Association now in progress is the "Los Angeles County Health Defense Exhibition," to be held on February 2 to 9 inclusive, at the Shrine Civic Auditorium Ballroom in Los Angeles. Mr. Guy L. Bowe, who was Director of Scientific Exhibits at the Golden Gate International Exposition of San Francisco, has charge of this activity. More than 60,000 square feet of space will be utilized to present to the people of Los Angeles County a dramatic story of what Medicine means to them. The week will be designated as "Los Angeles Health Defense Week."

LOUIS A. ALESEN,
Secretary.



THIRD DISTRICT

Kern, San Luis Obispo, Santa Barbara, and Ventura Counties; Louis A. Packard, Bakersfield, Councilor.

Kern County Medical Society

The Kern County Medical Society holds its meeting on the third Thursday evening of each month, except in June, July and August, at the Motel Inn, Bakersfield. One meeting is held yearly in Taft. The membership has increased greatly in the past year, necessitating a change from the previous meeting places at the Mercy Hospital and the Bakersfield Firehouse Auditorium. On January 1, there were sixty-four members.

The outstanding event of the past year was the Postgraduate Conference in Bakersfield on March 16, with an attendance of over one hundred physicians from the Third District. The Third District has the distinction of having been the first district group to inaugurate postgraduate conferences (in 1938). Speakers this year included Chauncey Leake, Ph. D. and Dr. Hans Lissner of the University of California Medical School. Drs. J. H. Inman, James Stanton, and Roderick Ogden served on the Committee of Arrangements.

The Society sponsored a large dinner meeting for business people of Kern County to explain the California Physicians' Service, and the response was most gratifying. Dr. Dewey Powell was the principal speaker, and many questions regarding the California Physicians' Service were asked of the representatives present. Dr. L. A. Packard, Councilor for the Third District, is also Deputy Medical Director for the California Physicians' Service, with Dr. William H. Moore and Dr. Carl Moore as administrative members for Kern County.

The Society has formed a Speakers' Bureau and hopes to enlarge its scope of activities in 1941, as the need has been long felt. Dr. L. A. Packard, Dr. C. I. Mead, and Dr. Roderick Ogden are serving on the committee.

During 1939-40 the Society also cooperated in a tuberculosis case-finding project with the Kern County Tuberculosis Association, and over two hundred chest x-ray films and tuberculin tests were provided for low-income private patients. These were interpreted by a committee of So-

ciety members, Drs. Seymour Strongin, Eric Colby, and Sophie M. Loven. Interest in the tuberculosis problem was stimulated, and two early adult cases were discovered. The cost of the project was approximately \$1,000.

Speakers and their subjects for the year included: Mr. Ross Marshall on "Work of the Public Health Committee"; Dr. Charles E. Smith on "Coccidioidomycosis"; Dr. Arthur Kirchner on "Gastroscopy"; Dr. Lowell S. Goin on "X-ray Treatment of Carcinoma of the Bladder"; Dr. Harold Thompson on "Surgery of Peptic Ulcer"; Dr. L. G. Hunnicutt on "Effects of Drugs on Respiratory Membranes"; Dr. A. G. Foord on "The Anemias"; and Dr. C. Orr on "Treatment of Anemia." Dr. Lloyd Fox served as program chairman.

The Society has contributed to the National Physicians' Committee and to the Public Health League, and has aided the latter organization in defeating the compulsory health insurance bill.

Kern County has two large migrant camps at Arvin and Shafter. Through the Agricultural Workers' Health and Medical Association, physicians have given professional service to the migrant farm laborer.

A special session on obstetrics was presented by Dr. William B. Thompson, and another refresher course is planned for the coming year.

Society members have participated actively as individuals in community affairs, serving on the Community Chest, the Kern County Tuberculosis Association, the Boy Scouts, and other service organizations. Dr. L. A. Packard spoke at a Community Needs Conference in February, 1940.

Officers during 1940 were: C. S. Compton, president; J. H. Hinman, vice-president; Eric F. Colby, secretary.

Serving on the Board of Directors were: Drs. F. J. Gundry, P. J. Cuneo, C. I. Mead, R. A. Ogden, William H. Moore, H. W. Lange, and Seymour Strongin. Delegates were: Drs. F. J. Gundry and C. S. Compton, with Drs. W. H. Moore and E. F. Colby as alternates.

The Society appreciates the cooperation of the Woman's Auxiliary in entertaining the wives of visiting physicians during the Postgraduate Conference, and the splendid publicity given by the local press, especially to the Conference and to the California Physicians' Service dinner.

ERIC F. COLBY,
Secretary.



San Luis Obispo County Medical Society

The year closes with thirty active members of the Society, and only two eligible physicians in the county not members. During the year, four members have moved.

Eleven meetings were scheduled. Scientific programs of exceptional interest were presented on "Epilepsy," by William Grant of Los Angeles; "Vitamin K," by S. P. Lucia of San Francisco; and "Fractures of the Spine," by W. P. Forcade of San Francisco.

The Society maintains no headquarters and publishes no bulletin. Members of the Society are divorced from the county hospital and indigent medical service. Several members have participated in the school health programs and clinics sponsored by the Health Department.

E. M. BINGHAM,
Secretary.



Santa Barbara County Medical Society

The Santa Barbara County Medical Society is composed of 113 active members, who make up about 95 per cent of the licensed physicians in the county. The regular meetings of the Society are held on the second Monday evening of each month, except July and August. The meetings are held in the auditorium of the Santa Barbara Cottage Hospital, except the January meeting, which is always a dinner meeting, and was held this year at the Santa Maria Club in Santa Maria. The Society chartered a Greyhound bus to take the members residing in Santa Barbara to this meeting. It is the policy of the Program Committee to invite speakers who are recognized authorities in their field to speak at the regular meetings. This year the Society has been unusually fortunate in obtaining outstanding speakers for its programs. In spite of this, attendance has been poor, and this we believe is attributable to the many calls made on the members' time for attendance at other meetings. It is my impression that this failure of the members to attend regular meetings of their local societies is a common condition throughout the state. This situation renders it difficult to transact the business of the societies in a truly representative manner, and is a condition meriting the best thought of the officers of the local and state associations.

This Society has no official headquarters or clubrooms; it does, however, publish a mimeographed bulletin which has been of some benefit in disbursing information to the membership.

The Tuberculosis Committee of the Society has conducted, in connection with the local Tuberculosis Association, a case-finding clinic this summer and fall with very satisfactory results. The Cancer Committee also conducted a most successful campaign in the spring, in which there was the fullest coöperation of the press, service clubs, and other organizations of this type.

D. H. McNAMARA,
Secretary.

Ventura County Medical Society

The Ventura County Medical Society at the present time has fifty-four active members. Ten new members were admitted during the present year. By transfer we lost one member, but gained another. A total of sixty-four physicians are licensed to practice in the county. In addition, there are fifteen osteopaths and twelve chiropractors.

Ten meetings have been held during the year, one being a joint session with dentists, nurses, and pharmacists. State Senator J. J. McBride and State Assemblyman Roscoe Burson were present as guest speakers. Our Society meets at the Ventura Country Club at Saticoy, each meeting being preceded by a dinner, because we have found that this makes for a better attendance.

Our postgraduate activities have been carried on with the other county units in our councilor district. The Woman's Auxiliary has been a great help in the matter of public health education, and has held four meetings during the year. Several members of our Speakers' Bureau have appeared before service clubs, women's clubs, and church groups. Cordial relations are maintained with the local newspapers.

Medical Preparedness coöperation has been carried forward in a satisfactory manner. Our members have been active in support of the California Physicians' Service. The indigent sick are largely cared for in the county hospital, and its clinics, but in some of the outlying districts of the county the work falls upon the local physicians. There are no migrant camps in Ventura County.

About one-half of our members hold membership in the California Public Health League. The Public Health Department of Ventura County is on a full-time basis, and the health officer maintains cordial affiliations with our county society.

A. A. MORRISON,
Secretary.



FOURTH DISTRICT

Calaveras, Fresno, Kings, Madera, Mariposa, Merced, San Joaquin, Stanislaus, Tulare, and Tuolumne Counties; Axel E. Anderson, Fresno, Councilor.

Fresno County Medical Society

Membership of the Fresno County Medical Society is 142 active, with ten additional members being accepted during 1940, of whom six are new members and four transfers from other societies. During the year we have lost two members by death: Dr. J. H. Pettis and Dr. R. B. Tupper. Three members have been transferred during 1940 to other societies. There are 162 licensed physicians and surgeons in Fresno County.

The regular meeting of the Fresno County Medical Society is held on the first Tuesday evening of each month at the University Sequoia Club in Fresno. The meetings are usually preceded by a dinner, followed by a short business session, which is then followed by a scientific meeting. Usually the speaker at this meeting is a guest from San Francisco or Los Angeles, or any member of our profession who has gained national prominence and who is available for our meeting. There are no meetings held during July and August. One meeting each year is a joint meeting with the members of the legal and dental professions of this community, and one meeting is usually devoted to a joint meeting with the Woman's Auxiliary.

During 1940, Fresno County Medical Society held a special dinner meeting for some of the employers of Fresno in order to introduce to them the California Physicians' Service.

J. E. YOUNG,
Secretary.

Kings County Medical Society

Kings County Medical Society reports a total of nineteen active members, two new members having been added to the roll during the past year. One member was lost through death.

Five meetings were held during the year. The Woman's Auxiliary existed for a time, but later disbanded. We believe the indigent sick in the county are well cared for. Kings County has a part-time health officer.

WILLIAM A. JOHNSTONE,
Secretary.

Merced County Medical Society

Membership—Thirty-nine members: active, 34; transferred, 3; deceased, 1; new members, 1.

Number of Meetings—Regular meetings to date, 7. In addition, an annual picnic was held on May 20. Summer recess was taken during June, July, and August.

Guest speakers were as follows:

January—Dr. Max Goldstein, Fresno: "Common Eye and Ear Conditions."

February—California State Secretary Dr. George H. Kress: "General Matters Concerning Medicine Throughout the State."

March—Dr. William Adams, Jr., Fresno: "Peritoneoscopy."

April—Doctor Parch, Oakland: "Endocrine Disturbances."

May—No guest speaker was had and the meeting was turned over to Dr. E. A. Jackson of Atwater for his delegate's report. Thereafter Dr. E. R. Fountain of Merced entertained the members by telling of the Santa Barbara Spring Grandees' Ride.

September—No guest speaker was had, as there was considerable business to take up after the summer recess.

October—Doctor Scarborough, Fresno: "Malignancy of the Colon and Rectum."

Woman's Auxiliary—The Auxiliary has been very active and helpful. They meet at the same time and in the same place as the County Society.

JAMES A. PARKER,
Secretary.



San Joaquin County Medical Society

The San Joaquin County Medical Society has 116 active members as of December 1, 1940. There are four retired members. Since December 1, 1939, the following members of the San Joaquin County Medical Society have passed away: E. L. Blackmun, W. W. Fitzgerald, Edmond Frost, and B. J. Powell. The following new members since December 1, 1939, have joined the Society: Louis Ghiglieri, Edmond P. Halley, Helen L. Starbuck, Robert Dyar, Elmer Smith, and M. Edelstein.

We hold ten regular meetings a year, on the first Thursday of each month. There are no meetings held during July and August. The meetings are customarily held in the Medico-Dental clubrooms in the Medico-Dental Building, Stockton. We have as a feature the June meeting, which is customarily under the auspices of the members in Lodi. This meeting is usually held at Valley Springs. We usually attempt to have some person speak on a medical subject usually not scientific. This year we were honored at the June meeting by having Paul de Kruif as our dinner guest. The regular meetings have a paper by a Bay area clinician.

The San Joaquin County Medical Society has clubrooms in the Medico-Dental Building in Stockton. This year the Society has started what we hope to be a tradition and that is, the honoring of the oldest active practitioner of medicine who is a member of the Society. This honoring will be done by a dinner meeting dedicated to him and the presentation of a suitably inscribed jewel to wear.

We have a very active Postgraduate Committee which has ably functioned since its beginning six years ago. The Committee presents, for a fee of \$5, a course of very well thought-of clinical demonstrations and lectures. We also have the advantage of the Woman's Auxiliary, which has done valuable contact work in medicine in general. We have developed a Speakers' Bureau in the last year. We have had sixty or seventy talks presented through this Bureau. Our relation to the local newspapers is exceptionally cordial, entirely through personal contact.

G. H. ROHRBACHER,
Secretary.



Stanislaus County Medical Society

The membership of the Stanislaus County Medical Society is now 48, two resident physicians of the Society joining in November. There have been three new members during the year 1940. There are no deceased members and none were lost by transfer. There are, however, two retired members. There are about sixty licensed doctors of medicine in the county, some of whom are inactive and have never been members of the Medical Society. There are four osteopaths in the county, one new for the year. There are fourteen chiropractors, with one new member.

Nine meetings are to be held during the year, none during the months of July, August, and September on account of the summer heat and vacations. The meetings are regularly held in Modesto at the Hotel Hughson on the second Friday of each month. Dinner is served at 7:30 p. m., followed by a business meeting, then by the regular speaker, usually one from San Francisco on the teaching

staff of either the Stanford or the University of California Medical School. The Society occasionally holds a joint meeting with the legal profession. The Society has no post-graduate conferences of its own, but is regularly invited to the conferences of the San Joaquin County Medical Society held in Stockton each year.

The Society has a Woman's Auxiliary, which was organized a year ago. Although the Auxiliary has not obtained its maximum functioning capacity, it is improving rapidly and seems to be definitely established. It meets at the same time as the County Medical Society, but as a separate group. It worked on the last Christmas Seal sale, helped defeat Proposition No. 2 on the last November ballot, is sponsoring an occupational therapy program at the County Hospital for tuberculous patients, and has aided in the Medical Preparedness program.

The County Society has no Speakers' Bureau or medical library. The Society passed a resolution two years ago against doing lodge practice, and at present, as far as is known, only one physician is doing that type of work, and he is not a member of the County Medical Society. In this connection, the Legal Counsel of the California Medical Association informed me that such practice was illegal because of no free choice of physician and because medical care was an incentive for membership.

The Medical Preparedness program has been carried out and all physicians, as far as known, have turned in their questionnaire. Practically all the physicians are members of the California Physicians' Service. No great interest has been shown in the national physicians' committee for the extension of medical service. There are no special problems in the connection of needy physicians. We have a full-time county health officer. We are in need of more nursing service in the schools.

In the past year the Modesto Board of Education appointed a physician medical director and adviser of school health. This physician is carrying out the program of the American Medical Association and other medical groups in collaboration with national educational groups.

HOYT R. GANT,
Secretary.

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Tulare County Medical Society

The Tulare County Medical Society has held two regular meetings since the summer vacation period. These meetings followed the usual lines of a dinner followed by a business meeting and an educational portion. The educational portion consists of the presentation of a clinical case followed by a general discussion. The guest speaker follows with his presentation. These meetings are held on the fourth Sunday of each month.

On November 19, the Tulare County Medical Society entertained, at a dinner, about one hundred business men, each of whom has a pay roll of twenty or more. To this group, Dr. Dewey Powell of Stockton and Mr. Howard B. Rector of Fresno presented the aims and purposes of the California Physicians' Service. Seemingly, considerable interest now exists among this group. Since the meeting we have been able to direct several inquirers to Mr. Rector. The Society members of this district are encouraged that the California Physicians' Service is now available to employers in our vicinity. We thank Doctor Powell and Mr. Rector for their services.

The Society regrets the loss of Dr. Ellis Sox as Tulare County Health Officer. His industry and ability have won for him a position in the State Department.

The Society membership has been reduced to forty-seven by the death of Dr. Ward Zeller. Dr. George Kieper, formerly of Los Angeles, has transferred his membership to the local Society. Doctor Kieper entered Doctor Zeller's office some months prior to Doctor Zeller's death. Three applications for membership are on file. We list one retired membership. We have an active Woman's Auxiliary.

FORREST G. POWELL,
Secretary.

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FIFTH DISTRICT

Monterey, San Benito, San Mateo, Santa Clara, and Santa Cruz Counties; R. Stanley Kneeshaw, San Jose, Councillor.

Monterey County Medical Society

The roster of the Monterey County Medical Society contains sixty-seven active members. During the present year four new men have been admitted to membership and one has been transferred to another county. The Society has four retired members on its rolls. In addition to the regular membership, all officers of the Medical Corps posted at the Presidio of Monterey and Fort Ord are honorary members, and are entitled to all the privileges of membership except that of voting. At present there are approximately 130 medical officers in the region. At a regular meeting of the Society, Dr. L. A. Emge of Stanford Uni-

versity Medical School was elected to honorary membership as a token of appreciation for his work in the Postgraduate Conference held in October.

There are ninety-eight licensed physicians practicing in Monterey County. In addition, there are eight osteopathic physicians and ten chiropractors.

Nine regular meetings are held each year, there being no regular meetings during the summer months of June, July, and August. This year four special meetings were held to discuss special problems for which adequate time at the regular meetings was not available. These included one meeting for a report from several members of the Army Medical Corps as to the rôle of the civilian physician in the present emergency; another meeting was devoted to the study of a new constitution and by-laws, and a fee schedule.

The meetings are held alternately at Hotel Del Monte and Santa Lucia Inn in Salinas, and notices of the meetings are mailed to members by the Secretary. On several occasions this year joint meetings with the Santa Cruz and San Benito County Societies have been held.

The final meeting of the year will include members of the local association and officers of the Army Medical and Dental Corps.

During the present year the regular meetings have had as guest speakers two or three men from the University Medical Schools in San Francisco. In January, in addition to Dr. C. A. Dukes, Past President of the California Medical Association and Dr. George H. Kress, Secretary-Treasurer of the California Medical Association, Dr. Dwight Wilbur read a paper on the "Present Status of Vitamin Therapy."

In February the meeting consisted of a concluding session of an all-day postgraduate symposium on the general subject, "Gastro-Enterology." Dr. Fred Kruse of the University of California Medical School and Drs. Eric Liljencrantz and David Wood of the Stanford University Medical School were the speakers.

In March Dr. Leo Eloesser read a paper on "Surgical Diseases of the Chest," and Dr. L. Henry Garland discussed "Problems in Roentgen Diagnosis of Diseases of the Chest."

In April Dr. E. B. Shaw of San Francisco spoke on "Exanthemata," with special emphasis on scarlet fever.

The May meeting was devoted to a discussion of "Newer Developments in Ophthalmology and Otorhinolaryngology of Interest to the General Practitioner." Dr. Otto Barkan and Dr. Lewis Morrison were the speakers.

In September a paper by Dr. Gerald O'Connor on the "Management of Surface Injuries," and another by Dr. Jesse Carr on "Fluids, Salt, and Protein in Surface Injuries" were read.

The October meeting consisted of the second session of the Postgraduate Conference on Obstetrics and Gynecology. Dr. L. A. Emge spoke on "Toxemias of Pregnancy."

The scientific program of the November meeting was given by Dr. Joseph Meherin on "Lesions of the Upper Extremities," and by Dr. J. Nelson Howard on the "Newer Aspects of the Pathological Physiology of Tendons."

During the course of the year a Constitution Committee prepared a new Constitution and By-Laws, and in cooperation with a Committee on Fee Schedule incorporated a new fee schedule into the By-Laws.

The Public Health Committee has done considerable work during the year on the problem of vaccinations and immunizations and tuberculin testing of school children.

Two Postgraduate Conferences were held this year. The first, in February, was devoted to the subject, "Gastro-enterology." In charge of the conference were Dr. Fred Kruse of the University of California Medical School and Drs. Eric Liljencrantz and David Wood of Stanford University Medical School. The morning session was a clinical conference, held in the Monterey County Hospital. In the afternoon a clinical-pathological conference was held at the Santa Lucia Inn. At the evening session each discussant read a paper. Doctor Kruse spoke on "Newer Developments in Diagnosis and Therapeutics of Peptic Ulcer"; Dr. Eric Liljencrantz talked on "Carcinoma of the Stomach"; and Dr. David Wood concluded with "Pathological Comments."

The second Postgraduate Conference was held in October, and was given over to obstetrics and gynecology. The afternoon session at the Monterey County Hospital, with a discussion of cases, was presided over by Drs. L. A. Emge and C. F. Fluhmann, both of the Stanford University Medical School. In the evening session, Doctor Emge read a paper on "Toxemias of Pregnancy."

There is a Woman's Auxiliary to the Monterey County Medical Society, which holds its own meetings at different times from the regular meetings of the County Society. The Auxiliary has always given full cooperation to the Society in all matters in which it could be of service.

The Society does not maintain a regular Speakers' Bureau, but Dr. Mast Wolfson spoke before the Santa Cruz Kiwanis Club, on behalf of the California Medical Associ-

ation, on the subject "State Medicine Versus California Physicians' Service."

Cordial relations are maintained with the various newspapers in the county, and announcements of meetings have been made in the Monterey and Salinas papers.

The County Society maintains no regular library. The various hospitals in Salinas and the Monterey Peninsula have libraries which are supported by the hospital staffs.

Most of the members of the Monterey County Medical Society have registered with the American Medical Association for medical preparedness. Dr. Rollin Reeves of Salinas is in charge of the work in Monterey County. Dr. Garth Parker of Salinas is medical director of the Monterey County Draft Board, and other members of the Society are serving on the regular Selective Service organization in the county.

About 80 per cent of the County Society members are also professional members of the California Physicians' Service. No special problems regarding medical service groups have arisen in this county.

The indigent of the county are largely cared for through the County Public Health Department. General clinics are maintained in Salinas, Monterey and King City, and special groups, such as Chest Clinics and Well-Baby Clinics, are held throughout the county at appointed times. Members of the Society act as visiting consultants in these clinics and at the County Hospital in Salinas.

The Public Health Department is in charge of Dr. John C. Sharp, who is Medical and Health Director. His assistant is Dr. Dwight M. Bissell. In addition to the general county hospital, there is a tuberculosis sanitarium to which an addition has just been added, doubling its capacity to about seventy beds. A full-time Social Service Department is maintained at the county hospital, and in addition there is a full-time worker in Monterey.

Certain members of the Society are employed by the various schools as part-time school physicians. They cooperate and assist the County Public Health Department in its work of tuberculin testing, immunization, and vaccination.

ARNOLD MANOR,
Secretary.

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San Benito County Medical Society

The directory of the Board of Medical Examiners of the State of California gives the names of fourteen licensed physicians who are in practice in San Benito. The membership of our Society at the present time consists of seven of the licensed practitioners.

Meetings are held from time to time upon call of the president.

L. E. SMITH,
Secretary.

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San Mateo County Medical Society

The San Mateo County Medical Society has monthly meetings, with the exception of the vacation months—June, July, and August. These consist of a dinner, followed by a short business meeting and a discussion of some medical or surgical topic by someone well-grounded in the particular field under discussion.

In June the yearly barbecue was held, at which time scientific subjects were not discussed. Notwithstanding, all attending enjoyed themselves.

No postgraduate studies have been pursued because of the proximity of our county to San Francisco and the constant opportunity there for postgraduate work.

The Society has continued to grow during the past year, and the present membership is 100 per cent of eligible physicians.

R. F. MONTEITH,
Secretary.

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Santa Clara County Medical Society

The Santa Clara County Medical Society continues to grow. Beginning the year with 187 members, thirteen new members were elected, but one member was lost by death, one by resignation, and one by transfer, making the net gain for the year ten members. Membership at the end of the year is, thus, 197. There are pending ten applications, which will put membership well past the 200 mark shortly after the first of the year.

The eight meetings so far held this year have continued the past high standard of scientific programs. Beginning with the County Hospital meeting in January, a scientific program was presented by the resident staff. Outstanding speakers have been: Dr. Dwight Wilbur, discussing vitamin-deficiency states; Dr. Hans Lisser, sex hormones; Dr. Louis Langstroth and Dr. J. B. Josephson, arthritis; and Dr. Mayo Soley, hyperthyroidism. Scientific, but in a different way, was the address of Dr. William Lautz, professor of Slavic languages at Stanford University, who, at the April meeting of the Society in Palo Alto, took as

his subject, "The Philosopher Looks at Medicine." Rebuttal to Dr. Lautz was given by Dr. William Dock of San Francisco, pathologist. The June meeting was the traditional golf tournament and barbecue, held this year at the San Jose Country Club.

A change in meeting time, from the third Wednesday to the third Monday, was made in September. Another innovation has been the holding of dinner meetings with a scientific program following. It was felt that meeting at dinner would add interest and increase the sociability of Society meetings. The response to both changes has been good. The interest of meetings has also definitely been increased by referring routine business to separate meetings of the Council, allowing more time for scientific speakers at meetings of the Society.

Nothing that could be considered a major problem has confronted the Society the past year. Relationships of members within the Society, and between the Society and the lay public, have been cordial. These facts can be taken as the best indication that the Society is efficiently performing its most important functions of fostering pleasant and stimulating professional and public relations. It is hoped that this success may be continued.

LESLIE B. MAGOON,
Secretary.

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Santa Cruz County Medical Society

Under the able leadership of President A. F. Giberson of Watsonville, the Santa Cruz County Medical Society is concluding a very successful year. As has been its habit for many years, the Society has held monthly meetings (except June, July, and August) at the Club Rio del Mar, Aptos, which is conveniently located for both the Santa Cruz and Watsonville members, when it has been customary to meet for dinner previous to the program of the evening. During the year the following speakers have appeared and the following programs were presented:

February 6—Dr. David A. Ryland, San Francisco: "Nephritis and Hypertension."

March 6—Joint meeting with Santa Cruz County Bar Association. Dr. Zera Bolin, San Francisco: "Medico-Legal Subjects."

April 2—Dr. H. Spencer Hoyt, Monterey: "Symposium on Urology."

May 14—"Symposium on Tuberculosis," with Doctors Sidney Shipman, Charles Ianne, and John Fuller participating.

September 3—Dr. Frederick Fender, San Francisco: "Epilepsy and Convulsive States."

October 1—Dr. Merlin T.-R. Maynard, San Jose: "Symposium on Dermatology."

November 5—Dr. Frank Lowe, San Francisco: "Diagnosis and Treatment of Congenital Dislocations of Hip."

At the present time there are forty-two members in the Society. This number represents practically 100 per cent of those actively engaged in practice in the county.

The Santa Cruz County Medical Auxiliary has cooperated during the year to the fullest extent in matters of policy, campaigns, educational programs, etc., and the value of this cooperative endeavor and of its conscientious officers cannot be overemphasized.

SAMUEL B. RANDALL,
Secretary.

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SIXTH DISTRICT

San Francisco County; John W. Cline, San Francisco, Councillor.

San Francisco County Medical Society

The total number of active members of the San Francisco County Medical Society is 991; seventy-one were admitted during 1940. Some thirty-five scientific meetings were held during the year. Various other scientific organizations used the headquarters of the Society for special meetings during the year.

The Society is proud to report that the mortgage on its home, which was purchased in 1926, has been paid in full. Credit for this is due to many members, but especially to Dr. William C. Voorsanger, who was tendered the following resolution at the regular October meeting of the Board of Directors.

WHEREAS, Medical societies, like most organizations, exist and flourish under the guidance, hard work and encouragement of a handful of their members; and

WHEREAS, One of the most arduous and least-appreciated duties of a member is that connected with financing the organization; and

WHEREAS, Of a small number of members who worked diligently on securing the return of gold notes purchased by members to finance its new building, one member is outstanding, succeeding in securing the return of notes in the sum of \$33,250; now, therefore, be it

Resolved, That the Board of Directors hereby acknowledges with thanks the remarkable work of that member, William C. Voorsanger, in this connection, and expresses its gratitude to him for his untiring efforts on behalf of his profession; and be it further

Resolved, That copies of this resolution shall be spread upon the minutes of this Society and transmitted to appropriate persons.

The above resolution was adopted unanimously at the regular October, 1940, meeting of the Board of Directors of the San Francisco County Medical Society.

A printed *Bulletin* is issued monthly for the information of members. This has contained monthly articles dealing with the Municipal Employees' Health Service System, one of the most important compulsory health insurance ventures in this state. Readers are referred to the various issues of this *Bulletin* for details concerning the present status of the System.

The Society secured the adoption of a special amendment to the city charter, designed to improve the operation of the Health Service System. This was adopted by the voters, two to one, at the regular November election. Credit is due to many groups for the successful adoption of this amendment, including the special Charter Amendment Committee, composed of Drs. Dorothy W. Atkinson (chairman), Lawrence R. Custer, Genevieve F. Gaffney, Thomas J. Lennon, Mary E. Mathes, Charles A. Noble, Jr., Guy D. Schoonmaker, and Wesley E. Scott. As in many other Society ventures, the Woman's Auxiliary was of great assistance in this task.

The Committee on Professional Conduct has done Trojan work during the year, and is of immense value in protecting the local good name of the medical profession, to say nothing of being a powerful factor in maintaining the availability of malpractice insurance.

A special luncheon of the Committee on Publicity was held with the city editors of the four large daily newspapers, and considerable progress was achieved in the problem of mutual understanding between the daily press and the profession on the thorny question of dissemination of medical news of a factual type. The importance to the public of California Physicians' Service and of medically approved hospitalization insurance schemes was stressed at this luncheon.

The Department of Public Health has continued to cooperate with the County Medical Society in a most constructive manner, and has furnished innumerable valuable news items and reports for our monthly *Bulletin*. The sincere thanks of the medical profession in San Francisco are due to Doctor Geiger for his unremitting interest in our County Medical Society affairs.

As we go to press, the problem of Medical Preparedness has become our number one concern, as it must be of all societies. We are endeavoring to cooperate in every way possible with Doctors Dukes and Gilman and the other officers of the California Medical Association, who are devoting so much of their time and energy to this problem.

L. HENRY GARLAND,
Secretary.



SEVENTH DISTRICT

Alameda and Contra Costa Counties; Oliver D. Hamlin, Oakland, Councilor.

Alameda County Medical Association

The Alameda County Medical Association, with 611 members, not only stands at the highest point in its history in total membership, but has a larger percentage of all doctors of medicine practicing in this county within its fold than ever before. During the past year fifty-two members were added and twenty-eight lost, seven of whom were claimed by death.

Ten regular general meetings were held, nine at our usual meeting place in the city of Oakland and one at the State Home for the Deaf in Berkeley. At this latter meeting, the Staff of the Home presented a very interesting program, illustrative of their methods of instructing the deaf and hard of hearing. The scientific programs of our regular meetings were presented, for the most part, by our own members; but four papers were given by invited guests. One meeting was devoted to reports from Past President Dukes and Secretary Kress of the California Medical Association. One joint meeting was held with the dentists, and the local pharmacists were our guests on one occasion.

A very successful Doctors' Hobbies Show was held during the year; and, while not one of our official functions, it was staged largely by our members and was heartily supported by the Association.

All routine business was transacted by the Council, which held twelve regular and one special meeting.

Our Association maintained a library, consisting of 8,285 volumes, with ninety-one current medical journals regu-

larly received, and we have had a justifiable pride and satisfaction in watching this project grow in size and usefulness from year to year.

An excellent understanding exists between the Alameda County Medical Association and the local newspapers, in which publicity space is generously given whenever requested.

Our Association is fortunate in that it has a vigorous Auxiliary which is also steadily growing in size and importance. The assistance of this organization in many worthwhile projects is, therefore, most gratefully acknowledged. The Association's successes, in its many attempts to improve public relations, is due in large measure to the faithful and untiring efforts of the Woman's Auxiliary.

GERTRUDE MOORE,
Secretary.



Contra Costa County Medical Society

The Contra Costa County Medical Society has held ten meetings during the year: one each month, except in July and August. Most of the meetings were held in Richmond, but occasionally they are held in other cities in the county.

We have fifty-four active, and two retired members. We have a guest speaker at each meeting.

This past year, on October 21, Dr. Edward R. Guinan of Richmond was awarded a fellowship in the American College of Surgeons, and because of the merit of his record, he was given a second prize at Chicago.

The Woman's Auxiliary holds its meetings on the same evening as those scheduled for our Society. Good relations are maintained with the county newspapers.

Effort is made to cooperate in all state and local health work.

L. A. HEDGES,
Secretary.



EIGHTH DISTRICT

Alpine, Amador, Butte, Colusa, Eldorado, Glenn, Lassen, Modoc, Placer-Nevada-Sierra, Plumas, Sacramento, Shasta, Sutter, Tehama, Yolo, and Yuba Counties; Frank A. MacDonald, Sacramento, Councilor.

Butte-Glenn County Medical Society

Butte-Glenn County Medical Society has forty-four members in the year 1940. Accessions to membership included five new members and three physicians by transfer. One member was lost through death. Butte and Glenn counties have a total of fifty-four licensed physicians who are in active practice.

Our Society meets in different cities, the programs being given largely by guest speakers from San Francisco. A Postgraduate Conference was held at the County Hospital. Butte-Glenn cooperated in the District Postgraduate Conference at Lake Tahoe. The Woman's Auxiliary has been active, and has given excellent aid whenever called upon. No Speakers' Bureau is maintained, but several members have given addresses before lay groups. Cordial relations have been maintained with the newspapers. Members of the Society have cooperated in the plans of Medical Preparedness, and have given good support also to California Physicians' Service.

The health officer of Butte County is also the county physician, and has two physicians to aid in the work at the county hospital.

J. O. CHIAPELLA,
Secretary.



Lassen-Plumas-Modoc County Medical Society

The Lassen-Plumas-Modoc County Medical Society has had a very successful year under the presidency of Dr. W. B. McKnight of Portola.

Three successful meetings were held during this summer—one in Susanville, one at Doctor McKnight's summer home at Mohawk, and one at the summer home of Doctor Davis on Lake Almanor. Dinner was served before each of these meetings, and the Woman's Auxiliary held their meetings while the official county meeting was going on.

It is difficult to hold meetings during the winter because of snow and ice conditions, so no further meetings have been scheduled for this year.

The Lassen-Plumas-Modoc Medical Society has nineteen active members, or 75 per cent of the practicing physicians of these three counties.

BERNARD S. HOLM,
Secretary.



Placer-Nevada-Sierra County Medical Society

The name of this Society has been changed recently from the "Placer County Medical Society" to "Placer-Nevada-Sierra County Medical Society." It was the opinion of the

officers and members that, as the membership is recruited from the medical profession of these three counties, the name "Placer County Medical Society" was not correctly descriptive of the geographical boundaries of our component society.

The annual meeting is held early in November of each year. During the past medical year the officers have been: President, William M. Miller of Auburn; Vice-President, Lucas W. Empey of Roseville; Secretary-Treasurer, Robert A. Peers of Colfax; delegate to the State Society, Lucas W. Empey of Roseville; alternate, Mildred E. Thoren of Weimar.

At the annual meeting held on November 9, 1940, the following officers were elected to serve until November, 1941: President, Lucas W. Empey of Roseville; Vice-President, Vernon W. Padgett of Alleghany; Secretary-Treasurer, Robert A. Peers of Colfax; delegate, William M. Miller of Auburn; alternate, C. Conrad Briner of Auburn.

Membership.—By the election of one member and the transfer from San Joaquin County Medical Society of another, at the meeting of November 9, the membership now stands at forty-seven, two of whom are retired members. During the year we have lost, by death, one member, Dr. V. V. Rood of Grass Valley. Our present membership is an all-time high.

There have been five meetings of the Society in the past medical year:

1. The annual meeting of November 4, 1939.
2. Dinner meeting of November 18, 1939, where a "Symposium on Alcohol and the Drunken Driver" was discussed by Dr. Edmund Butler of San Francisco, Mr. Lowell Sparks, District Attorney of Placer County, and Captain LaPorte of the California Highway Patrol.
3. Meeting of December 19, 1939, for the purpose of discussing "Well-Baby Clinics and Prenatal Clinics" with Dr. Ellen S. Stadtmuller of the State Department of Public Health.
4. Meeting of July 27, 1940, honoring Honorable Jerrold L. Seawell, President *pro tem.* of the State Senate, and our representative in the State Senate, and Honorable Allen G. Thurman, Assemblyman for the Sixth District. Dr. J. B. Harris of Sacramento was the guest speaker.
5. Meeting of September 28, 1940. Program was supplied by Dr. Robert A. Peers of Colfax and Dr. Daniel L. Hirsch of Grass Valley.

A report of each of these meetings has appeared in CALIFORNIA AND WESTERN MEDICINE. In addition, members of the Placer County Medical Society attended and took part in the Postgraduate Conference of the Eighth Councilor District held at Lake Tahoe on August 24 and 25, 1940. . . .

As stated above, the membership of our Society is at a new high. The members support the organization by their presence, and a feeling of good fellowship prevails throughout the three counties. The officers and members of the Placer-Nevada-Sierra County Medical Society wish to express their appreciation for the cooperation received from the state officers and for the sport and guidance by the Councilor of the Eighth District, Dr. Frank MacDonald of Sacramento.

ROBERT A. PEERS,
Secretary.

Sacramento Society for Medical Improvement

The Sacramento Society for Medical Improvement meets on the third Tuesday of each month. Meetings are held at the auditorium of the Sutter Hospital at Twenty-eighth and L streets. The meetings begin at 8:30 p. m. There were ten meetings last year. No meetings are held during the months of August and September. The December meeting of each year is entirely devoted to business of the Society and election of officers. One meeting each year is usually devoted to an informal discussion by members of the Society regarding travel to other medical centers, postgraduate work, etc.

No bulletin is published by the Sacramento Society for Medical Improvement.

There are now 159 active members in the Society. Twelve new members were added during the past year.

The Woman's Auxiliary to the Sacramento Society for Medical Improvement meets on the same evening as the County Society. Their activity has been of great benefit to organized medicine in this community.

We maintain a Speakers' Bureau and have had speakers appear before Parent-Teacher groups, Woman's Auxiliary, and several radio programs.

The Sacramento Society for Medical Improvement recently formed a committee for Medical Defense, Drs. H. R. Baird, O. F. Johnson, and H. S. Burden being appointed to serve for the coming twelve months.

GLENN E. MILLAR,
Secretary.

Shasta County Medical Society

During 1939 Shasta County Medical Society had seventeen active members. Of these, two have moved away and one, Dr. Ferdinand Stabel, was granted retired membership. That leaves us with fifteen members during 1940.

To these fifteen we have added eight new members as follows: Drs. John D. Briggs, Roland R. Jantzen, Harold R. Whiteside, Clarence H. Schilt and Julius M. Kehoe, three others having been received by transfer: Dr. Harold Kahn from Santa Barbara County, Dr. James B. Cutter from Santa Cruz County, and Dr. John B. McConnell from Butte County. In September, one of our members, Dr. Harold R. Whiteside, passed away.

There are twenty-five M. D.'s in Shasta County of whom eighteen belong to our Society, while three out of four physicians in Trinity County are members of our Society. We also have one member from Lassen County, giving us an active membership at present of twenty-two, with an attendance at meetings averaging 75 per cent. There are, besides, two osteopaths and four chiropractors in Shasta County.

Meetings are held once each month, except during June, July, and August, usually in Redding, on the second Monday of the month. The programs consist either of films, exhibitions, or an address by a guest speaker. The professional and beneficiary members of the California Physicians' Service were invited to the April meeting.

There has been no Postgraduate Conference during this past year, although the members have expressed their desire for such a conference; and it is hoped that one may soon be held at Redding or in one of the near-by cities.

The Society does not have a Woman's Auxiliary. A cordial relationship has been maintained with the local newspaper.

BERTRAM L. TRELSTAD,
Secretary.

Tehama County Medical Society

Tehama County Medical Society has a total of eleven members, one of whom was admitted during the current year. We lost one member through death.

Owing to the travel conditions, it has been found necessary to meet at different places, on call of the president. The members of the Society maintain an active interest in local matters.

FRANK J. BAILEY,
Secretary.

Yolo County Medical Society

The newly formed Yolo County Medical Society got under way on this evening of November 14 by formally adopting a constitution and by-laws at a special meeting held for this purpose. (By action of the House of Delegates and Council, the former Yolo-Colusa-Glenn County Medical Society was changed as follows: Colusa County becoming a part of the Yuba-Sutter-Colusa County Medical Society; Glenn County becoming a part of the Butte-Glenn County Medical Society; and Yolo County becoming a separate unit, as the Yolo County Medical Society.)

Out of twenty-seven physicians licensed to practice in Yolo County, twenty are listed as active members of the Yolo County Medical Society, and two applicants have been accepted for membership.

The active members are: Drs. W. J. Blevins, W. J. Blevins, Jr., A. M. Clark, E. K. Copeland, F. R. Fairchild, H. S. Graeser, E. H. Gray, C. K. Mills, R. E. Nichols, J. G. O'Hara, O. C. Railsback, C. S. Roller, J. W. Rovane, M. A. Waters, J. H. Woolsey, all of Woodland; T. E. Cooper, L. A. Cronan, W. T. Robbins, all of Davis; W. D. Garcelon of Esparto; and H. G. Potter of Winters.

The applicants approved for membership into the Yolo County Medical Society are Dr. L. S. Goerke of Woodland, the health officer for Yolo County; and Dr. M. N. Wilmes of Woodland, associate otolaryngologist on the staff of the Woodland Clinic Hospital.

Society meetings are held on the second Thursday evening of each month, except for the months of July and August. Until the annual meeting, which is to be held in December, the acting officers are as follows: E. K. Copeland, president; M. A. Waters, vice-president; W. T. Robbins, secretary-treasurer; J. H. Woolsey, State delegate; E. H. Gray, alternate State delegate.

The nature of future programs, speakers, and meetings will not be decided until the next meeting. However, it is the consensus of opinion that we shall be privileged to hear a number of outside speakers during the year as well as talks on special subjects by members of this Society.

It is of special interest that the American Medical Association questionnaire on Medical Preparedness is eliciting 100 per cent response among the physicians of this county. There is also a special committee at work, de-

termining the number, if any, of needy physicians or physicians' widows residing in this county.

The members of the Yolo County Medical Society feel that a good start has been made, and that more news of interest will be forthcoming within the next month or two.

WILFRED T. ROBBINS,
Acting Secretary.

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Yuba-Sutter-Colusa County Medical Society

This society started 1940 with nineteen members. Then during the early part of the year it elected two new members, and the consolidation of the three counties in June gave us a total membership of twenty-seven, which is the membership as of this date.

There are about half a dozen physicians in the community as a whole who are not members, and have never attended any of our meetings, even though invitations have occasionally been extended to them. There are several osteopaths, chiropractors, and herb specialists, as well as Christian Scientists, practicing their healing arts in this territory.

Eleven regular medical society meetings were held during the year, on the first Tuesday of each month, except May, which time conflicted with that of the California Medical Association at Coronado. Occasional special noon-day business meetings were held.

We have had nine distinguished guest speakers during the year:

C. W. Barrett, Stanford University Medical School. Subject: Treatment of Syphilis (lantern slides).

C. F. Norman, San Francisco. Subject: Calcium Metabolism as Related to Vascular Diseases.

Leo Eloesser, Professor of Surgery, Stanford University Medical School. Subject: Recent Developments in Surgery of Pulmonary Tuberculosis. (Lantern slides and working model of lungs.)

O. W. Jones, San Francisco. Subject: Head Injuries and Herniation of Nucleus Pulposus.

Sterling Bunnell, San Francisco. Subject: Reconstruction of Hands.

Robert A. Lyon, Consultant in Obstetrics, Bureau of Child Hygiene, Department of Public Health, California. Subject: Prevention of Toxemia and Treatment of Eclampsia.

William J. Kerr, Professor of Medicine, University of California. Subject: Angina Pectoris, Its Differential Diagnosis and Treatment.

Professor Ralph O. Baker, Science Department, Yuba Junior College. Subject: Recent Developments in Bacteriology.

J. B. de C. M. Saunders, Professor of Anatomy, University of California. Subject: Lesions of the Shoulder.

Yuba-Sutter-Colusa County Medical Society cooperated with the Eighth District Postgraduate Conference that was held at Lake Tahoe, at which time the possibility of organizing a Woman's Auxiliary was discussed.

On the Fourth of July, the Yuba-Sutter-Colusa County Society entered a medical decorated car in the Marysville celebration parade, the parade being over a mile long. This is the first time we have ever participated in such a community affair, and so the favorable comments which we received were very gratifying.

This society has also cooperated fully with all proposed Medical Preparedness plans.

The indigent in our counties are cared for by county hospitals, county hospital clinics, the Public Health Department, the State Relief Association, and the Agricultural Workers' Health and Medical Association. In Yuba County the Society members resident in Yuba and Sutter counties form the attending staff of the Yuba County Hospital. The staff physicians work with the hospital resident, under the direction of our Hospital Relations Committee, and on a rotating service of three months' duration. Ward rounds are held every Friday at 9 a. m., at which time the attending staff and visiting physicians go over the cases; examinations are made when and as indicated, according to individual patients' conditions, the case is then discussed by the attending men, and the possible medical and surgical program for each case is planned and then carried out by the resident physician and the immediate attending staff. The plan is working very smoothly, much to the satisfaction of the local physicians and to the Board of County Supervisors.

Work of Speakers' Bureau: Harold R. Hennessy appeared many times before various organizations on various topics of public health; G. S. Delamere addressed a group at Yuba Junior College on "Transportation of Fractures"; I. H.

Higgins, before a lay group, discussed the subject, "Early Days of Bacteriology"; Leon M. Swift, to the Knights of Pythias, gave a talk, "Benefits of a Blood Donors' Club"; Stanley R. Parkinson, in an address to the Lions Club, spoke on "Importance of Physical Examinations"; and Charles B. Kimmel, at a meeting of the Rotary Club, took as his subject, "Rheumatism."

LEON M. SWIFT,
Secretary.

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NINTH DISTRICT

Del Norte, Humboldt, Lake, Marin, Mendocino, Napa, Siskiyou, Solano, Sonoma, and Trinity Counties; John W. Green, Vallejo, Councilor.

Humboldt County Medical Society

For the year 1940 the Humboldt County Medical Society had thirty-seven paid-up members. This represents almost all the active physicians in this area. Most of the others who are licensed are retired from active practice; one physician is ineligible for membership because of unethical advertising. We have four osteopathic physicians and six chiropractors in the county.

Our medical society had seven regular meetings during the year. Three of these meetings were addressed by outside guest speakers. One Postgraduate Clinical Conference was held at the Humboldt County Hospital. Several moving-picture films of medical interest were shown during the year.

In April a joint dinner meeting was held by the physicians, dentists, pharmacists, nurses, and veterinarians, when the guest speakers were: Mr. Ross Marshall, Mr. Ben Read, Assemblyman Burns, and Senator Quinn. The main topic of discussion was legislation affecting our joint professions.

The Woman's Auxiliary of the Humboldt County Medical Society was organized this year. They have had a number of meetings, and show prospects of being a very valuable asset to the medical profession in this area.

We maintain a Speakers' Bureau, and have supplied speakers to numerous service clubs and other lay organizations.

Very little has been done by the California Physicians' Service in this locality, since there is a local organization offering practically the same service at a much lower rate.

J. S. WOOLFORD,
Secretary.

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Marin County Medical Society

The Marin County Medical Society has now forty-five paid-up members. During the year one new member was elected, one came in by transfer from San Francisco, and one went out by transfer to Stockton. No members were lost by death, and none retired.

There are two osteopaths in the county, who seem to be making a living. We have several chiropractors, who have been here for several years, but very little is heard about them. Generally, the county is free from cults. There are three young M. D.'s in the county who will probably join in 1941. Another has recently opened up an office and will probably be refused membership.

The Marin County Medical Society holds nine regular meetings each year. No meetings are held in the months of June, July, and December. The regular meeting time is the fourth Thursday evening of the month, and during the past year it has been held at the same place (Deer Park Villa, Fairfax). All have been dinner meetings, with a guest speaker from the profession. At the eight meetings we have had an average attendance of twenty-two. The best was thirty, and the poorest was seventeen. There are always a few guests present from out of the county. One midsummer social meeting was a decided success, being thoroughly enjoyed by all who attended.

The Society has no headquarters facility, which is a decided loss to its members, and no headway has been made in procuring the same.

Postgraduate work has been taken by several of the members in their respective fields, but without relation to the Society.

The Woman's Auxiliary has been a wonderful success. It meets at the same time and place as does the Society. They always have a good attendance and an interesting program. They bring the doctor-husbands along, so we have a much better average attendance, and a finer feeling exists among the members.

CARL W. CLARK,
Secretary.

Mendocino-Lake Medical Society

The number of active members in our Society for this year is thirty. There were three transfers to other county units, but we have three new members, which holds our membership to thirty.

In Mendocino and Lake counties we have forty-four doctors of medicine who are licensed to practice. Also one drugless practitioner.

The area of the two counties is extensive, and we find that four or five meetings annually is our best program, with from twenty to twenty-five members present. These meetings are held in different parts of the two counties. Our programs usually consist of one guest speaker, a medical motion picture, and a round-table discussion. Once a year the wives of members are invited, and they are now considering the establishment of a Woman's Auxiliary.

One Committee on Tuberculosis has recommended that testing be done in the schools in November, with x-rays in December, for readings in January, allowing the remainder of the school year for observation of positives.

Medical Preparedness has met with favorable response of the majority of our members.

ROYAL SCUDDER,
Secretary.

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Napa County Medical Society

Our medical society, one of the smallest in the state, has practically 100 per cent of eligible physicians of the county on its membership roll, and is active scientifically, professionally, and socially.

At a recent annual meeting the officers elected for 1941 were: R. W. Burket of Napa, president; I. E. Charlesworth of Imola, vice-president; M. M. Booth of St. Helena, secretary and treasurer; George I. Dawson of Napa, delegate; and Dwight H. Murray of Napa, alternate.

M. M. BOOTH,
Secretary.

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Siskiyou County Medical Society

During the year 1940 we have already had four meetings, and expect to have the fifth this coming month. Three of our meetings have been in the nature of clinical conferences, as one led by Dr. Dwight L. Wilbur on gastrointestinal diseases; one by Dr. Colin C. McRae on fractures; and one by Dr. John J. Sampson on heart diseases.

At the present time we have eighteen members in the Society, and Dr. Charles Pius has been president for the past year.

V. W. HART,
Secretary.

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Solano County Medical Society

The Solano County Medical Society has thirty-four active members, including one new member, who joined in 1940. There are two honorary members, who are also on the retired list. There are thirty-eight licensed doctors in the county, five of whom are retired. (Six United States naval officers are licensed, who do not practice privately.) There are two osteopaths practicing in Vallejo.

The Solano County Medical Society generally meets at the Casa de Vallejo Hotel, in Vallejo, on the second Tuesday evening of each month. We have had eleven meetings during our current year, missing a meeting in July. Generally, in July a tri-county meeting of the Napa, Sonoma, and Solano County Medical Societies is held. We also plan one meeting each year which is open to the public.

We have had interesting programs this year. On January 12, 1940, Ross Marshall of the Public Relations Committee of the California Medical Association and Ben Read, Secretary of the Public Health League, addressed the Society. Mr. Marshall stressed the need of more energetic public education on medical matters with which his committee had been charged. Ben Read discussed the success of the League at the recent session of the Legislature, and thanked various members for their aid in carrying out a successful public health program.

On February 13, 1940, a business meeting was held. A motion was made, seconded and carried, that a Woman's Auxiliary to the Solano County Medical Society be formed. Doctor Butler's letter, endorsing Dr. Henry Rogers for president of the California Medical Association in 1941, was read, and the Society voted to endorse Doctor Rogers. Dr. C. C. Purviance was elected to serve as an advisory member of the California Physicians' Service. The Well-Baby Clinic of the Vallejo Women's Club was discussed, as were plans for a venereal clinic under the direction of the public health officer, Dr. George O'Brien.

On March 12, 1940, Commander Brady, Medical Corps, United States Navy, presented a paper on "Kidney Stones."

Captain Gendreau, Medical Corps, United States Navy, discussed the paper from a surgical aspect, and Commander Fort, Medical Corps, United States Navy, discussed it from the x-ray aspect. Very interesting meeting, and the Medical Corps of the Navy at Mare Island was thanked by President H. Randall Madeley of the Solano County Medical Society.

On April 9, a Memorial meeting to Dr. B. J. Klotz, was held. The public was invited. A Memorial lantern for slides was presented to the Solano County Medical Society by friends and patients of the former Doctor Klotz. Members of Doctor Klotz's family were present. Dr. Ambrose Ryan presided. An excellent feeling of public esteem for the medical profession was shown at this meeting. Following the public exercises, the Society held an open discussion of well-baby and other clinics among the members of the medical society who were present.

On May 14, Dr. H. Glenn Bell of the University of California Hospital spoke on "Gall-Bladder Disease." A most interesting discussion from the floor followed; and this meeting could be considered a three-star session.

On June 11, the annual meeting was held at Mare Island Hospital of physicians attached to the Mare Island Navy Yard and the doctors of the Solano, Napa, Marin, Alameda, and Sonoma County Medical Societies and guests. Captain Davis, Medical Corps, United States Navy, read a paper on "Naval Aviation." Admiral Bagley spoke for the Navy Department. Doctor Davis illustrated his talk with motion pictures. Following this meeting a business session was held in Vallejo, at which "patient admissions" to the Vallejo General Hospital by a cultist practitioner were discussed. There was also a discussion of examinations of Girl and Boy Scouts for camps. A medical Speakers' Bureau was formed, and Doctors Jones, Snoddy, and Purviance volunteered for this activity. This was a four-star meeting.

No meeting was held in July, but on August 27 the annual tri-county meeting of the Napa, Solano, Marin, and Sonoma County Medical Society was held in Napa, with the members of the Napa County Medical Society hosts to the gathering. President Harry Wilson of the California Medical Association was the guest speaker. He astonished the writer with his "Philosophy of Life." This meeting was honored by the attendance of many distinguished guests, including Dr. George Kress, Dr. Philip Gilman, and President-Elect Henry Rogers. A four-star gathering.

On September 2, Dr. Amos Christie of San Francisco, a member of the State Board of Health, addressed the Society on recent advances in "Pediatrics," as well as his ideas about the way Well-Baby Clinics should be operated. This meeting was of great clinical interest to our members as well as allaying our fears about clinics in Vallejo. Military preparedness was also a topic of general discussion. Doctor Hauser was elected to membership. A four-star meeting.

On October 8, Dr. John Ewer, Jr., of Oakland, was the guest speaker, and took as his subject, "Common Gynecological and Obstetrical Problems." His remarks were followed by a round-table discussion, which resulted in a four-star meeting. This meeting was presided over by Doctor Gordon Bunney, vice-president, in the absence of Doctor Madeley, who was on vacation, after conducting all other meetings during the year of his presidency.

The Society has no headquarters at present, and no plans for any at the present time. Neither do we have a regular bulletin, communications being sent out from the secretary's office when necessary. We have carried on no post-graduate activities, as the members feel that they are close enough to San Francisco to participate in programs there.

A Woman's Auxiliary to the Solano County Medical Society was formed in August, 1940. This group is quite active and from present indications will be very helpful.

A Speakers' Bureau has been organized and is composed at present of Doctors Jones, Snoddy, and Purviance. We have no particular connection with any of the local newspapers, and we have no medical library.

The Solano County Medical Society always endorses legislation which is beneficial to the public health, and which does not tend to regiment the members of our Society. About 75 per cent of the members have filled out and sent in questionnaires to the American Medical Association.

The California Physicians' Service is not active in Solano County, and we participate in no hospitalization plans other than the California Physicians' Service.

Indigents are taken care of at the Solano County Hospital, which has a part-time, contract physician.

Our members support the California Public Health League, and about six members of the Society have supported the National Physicians' Committee for the Extension of Medical Service.

We have no local plans and no special problems at the present time in connection with needy physicians.

Solano County has a full-time public health officer, Dr. George O'Brien, and the members of the Solano County Medical Society work in collaboration with him.

Outside activities include a case-finding campaign for the Tuberculosis Association, which is conducted by the members of the Solano County Medical Society, and our members serve at the Well-Baby Clinic, conducted by the Vallejo Woman's Club, which is supervised by the full-time public health officer.

JOHN W. GREEN,
Secretary.

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Sonoma County Medical Society

One of the most important events during the past year for the Sonoma County Medical Society was the election of one of our oldest and most active members, Dr. Henry S. Rogers of Petaluma as president-elect of the California Medical Association for the coming year.

There are ninety-six registered physicians in the county, of which seventy-three are in active practice, sixty-seven of whom are members of the County Society. During the year six of our members, who were formerly residents in the County Hospital, transferred to other counties, and we received one new member by transfer from Lake County. We have now ten retired physicians who still maintain their license, two of whom were retired in the past year.

During the year, ten meetings were held at various cities in the county, there being no meetings during the months of July and August. The June meeting is a combined meeting of the Bar Association, Dental, Pharmaceutical, and Medical societies, which has become an annual get-together.

We have actively sponsored a Woman's Auxiliary during the past year, and were very fortunate in having Mrs. A. E. Anderson, the Auxiliary's state president, as guest speaker at a joint meeting in October.

The Medical Society, through its Public Relations Committee, has arranged for a weekly radio program, of particular interest to the lay people, over station KSRO, Santa Rosa. Our Speakers' Bureau, also sponsored by the Public Relations Committee, has provided guest speakers for various organizations of the county, including the Grange, Farm Bureau, and schools.

As a society, we do not maintain any medical library, as there is an excellent one at the Sonoma County Hospital, to which members of the Society have ready access.

We feel very fortunate in this county in having an up-to-date county hospital of 432 beds, including a tuberculosis unit, and a very coöperative Board of Supervisors, who have worked with the County Medical Society in making it a Class A institution. The hospital is recognized by the American Medical Association, the American College of Surgeons, and the American Hospital Association, and has a medical staff composed entirely of members of the County Medical Society. We have a full-time public health officer, and a public health department, recognized by the State Department of Public Health, and the National Bureau of Public Health, under county supervision.

This year, we feel, has been very successful for Sonoma County, and we are sure that our Society will continue to prosper during the coming year.

T. E. ALBERS,
Secretary.

NEVADA STATE MEDICAL ASSOCIATION

C. W. WEST, Reno.....President
H. A. PARADIS, Sparks.....President-Elect
HORACE J. BROWN, Box 698, Reno.....Secretary-Treasurer

Annual Session: Nevada State Medical Association

Abstract of the Minutes of the Annual Session Held at Las Vegas, Nevada, October 10-12, 1940

The thirty-seventh annual meeting of the Nevada State Medical Association was held at Las Vegas, Nevada, on October 10, 11, and 12, 1940. As a prelude to the scientific and business meetings, a boat ride on Lake Mead and barbecue on the shores of the lake were enjoyed by members and guests on the afternoon of October 10. This was followed by an evening of entertainment at the Elks Club, consisting of the showing of scientific motion pictures.

First Meeting, Friday, October 11, 1940

Morning Session

The first meeting of the thirty-seventh session of the Association was called to order on October 11 at the Elks Club by the president, C. W. West, at 9:35 o'clock. A brief address of welcome was given by President West, followed by announcements of changes in the program. The scientific program follows:

1. Victor Strong Randolph, Phoenix, gave a paper, entitled "Surgical Treatment of Pulmonary Tuberculosis," which was discussed by F. R. Mildren, C. W. Woodbury, S. L. Hardy, J. L. Robinson, E. E. Hamer, G. J. Sylvain, and V. S. Randolph.

2. L. E. Viko, Salt Lake City, gave a paper, entitled "Etiology and Treatment of Hypertension," which was discussed after the following paper was read.

3. Whitfield Crane, Oakland, gave a paper, entitled "Surgical Treatment of Hypertension," which was discussed by S. L. Hardy, L. E. Viko, and Whitfield Crane.

This concluded the morning session of the meeting and recess was taken for lunch, which was held at the Apache Hotel.

Afternoon Session

The afternoon session commenced at two o'clock, with a continuance of the scientific program.

4. Verne C. Hunt, Los Angeles, gave a paper, entitled "Surgical Management of Carcinoma of the Colon," which was discussed by R. A. Bowdle, N. F. Hicken, C. W. Woodbury, K. S. Davis, and V. C. Hunt.

5. Kenneth S. Davis, Los Angeles, gave a paper, entitled "Limitation and Evaluation of X-ray in Diagnosis of Disease of the Gall Bladder," which was discussed by R. R. Craig, K. J. Kraus, and K. S. Davis.

Doctor Davis' paper concluded the scientific program for the day, and a short recess was taken before commencing the business meeting.

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Business Meeting: Friday, October 11, 1940

The meeting was called to order by President C. W. West at 4:10 p. m., and proceeded as follows:

Reading of the Minutes.

The minutes of the last annual meeting were read by Secretary Horace J. Brown.

Report of Delegate to American Medical Association.

The delegate reported that he had been unable to attend the annual meeting of the American Medical Association. The alternate delegate not being present, no report was given.

Reports of Various Committees.

Judicial Committee.—No report.

Program and Scientific Work.—No report.

Military Affairs Committee.—D. J. Hurley, the only member present, stated that the Committee had not met and, therefore, had no report to make.

Necrology Committee.—J. L. Robinson reported the deaths of two members: A. W. Semmens, Winnemucca, and J. R. A. Lang, Reno; and two former members, Carl Lehnars, Reno, and W. H. Miller, Reno. It was moved by R. O. Schofield, and seconded by C. E. Secor, that resolutions be passed for nonmembers as well as for members and sent to the families of each, and so carried.

Public Health Committee.—E. E. Hamer, Chairman, read a lengthy report of the work accomplished by the Nevada State Department of Health during the past year, including the work of all of its branches. At the end of his report Doctor Hamer requested that the Association

appoint a special advisory committee of private physicians in the state to meet with the public health officials to coordinate the work of the coming year. Discussion was held as to whether these physicians should be scattered throughout the state or chosen from a central location. It was decided to select a committee from all over the state and to carry on its work by correspondence. Dr. Horace J. Brown suggested that instead of appointing a special committee for this purpose the regular Public Health Committee, consisting of three members, be increased to six or seven members and assume the additional duties. This suggestion was put in the form of a motion by R. A. Bowdle, seconded by Horace J. Brown, and so carried.

Industrial Health Committee.—A brief report of this committee was made by R. A. Bowdle.

Entertainment Committee.—No report.

New Business.

Secretary Horace J. Brown read a letter from Dr. George H. Kress, Editor of CALIFORNIA AND WESTERN MEDICINE, in which it was stated that the JOURNAL was to be considerably decreased in size and that it would be impossible to continue to print monthly letters from the Nevada Association or assure publication of all papers written by Nevada men. A discussion followed as to whether or not the Nevada Association should continue to be affiliated with this JOURNAL. A motion was made by Horace J. Brown that the Association sever connections with CALIFORNIA AND WESTERN MEDICINE. The motion was seconded by S. L. Hardy, and a standing vote was taken which resulted as follows: Affirmative, 12; negative, 1.

Election of Officers.

According to the constitution and by-laws, President-Elect H. A. Paradis advanced to the place of president, and First Vice-President George R. Magee advanced to the office of president-elect. It was moved by C. E. Secor, and seconded by F. R. Mildren, that John R. McDaniel, Jr., be made first vice-president. D. J. Hurley was nominated by R. R. Craig for second vice-president. Horace J. Brown was nominated by R. A. Bowdle for secretary-treasurer, and the nomination was seconded by R. O. Schofield. In accepting the nomination, Doctor Brown requested that he be permitted to have an assistant to take care of some of the duties of this office and was ordered by President West to employ necessary help at the expense of the Association. There being only one person nominated for each office, the above were unanimously elected to the office for which they were nominated. C. W. West was nominated by R. R. Craig to succeed Fleet H. Harrison as trustee for the two-year term.

Balloting on New Members.

The Secretary presented the names of the following applicants for membership, which were all accepted: P. F. Brabec, Fallon; William Morse Little, Reno; H. E. Lohlein, Reno; G. A. Ordeson, Kimberly; Karl Kraus, Las Vegas; Glenn C. Davis, Ely; Samuel R. Clark and Joseph B. Dolezal, both of Battle Mountain; Joseph H. Stickler, Stewart; Ira J. Seitz, Reno; Arthur R. Thompson, Minden; C. David Lambird, Sparks; F. W. Scott, Roland W. Stahr and George W. Hemminger, all of Reno.

Balloting on Honorary Members.

Following the usual procedure, all essayists not already members were elected to honorary membership in the Nevada State Medical Association.

Selection of Place for Next Meeting.

C. E. Secor invited the Association to meet at Elko. R. R. Craig expressed a preference for Reno. It was moved by Noah Smernoff, and seconded by R. A. Bowdle, that the 1941 meeting be held at Elko, and so carried.

At this time, President C. W. West presented the subject of Medical Preparedness and gave a report of his trip to Chicago, where he recently attended a conference on preparedness. The subject of the selection of members of the examining boards for the draft was discussed.

There being no further business, the meeting adjourned at 5:20 p. m.

A dinner dance was given for members of the Association and guests at the Yucca Club on Friday evening, October 11.

Second Meeting, Saturday, October 12, 1940

The meeting was called to order at 9:25 a. m. by President C. W. West. The scientific program was immediately taken up and was as follows:

1. Gerald Brown O'Connor, San Francisco, read a paper, entitled "Immediate Management of Surface Injuries." There was no discussion.

2. Roland W. Stahr, Reno, read a paper, entitled "Practical Points in Pediatrics," which was discussed by Noah Smernoff, W. B. Ririe, and R. W. Stahr.

3. Francis McKeever, Los Angeles, gave a paper, entitled "The Present Status of the Treatment of Fracture of the Neck of the Femur," which was discussed by H. T. Jones, Vernon Cantlon, J. H. Hastings, R. O. Schofield, and Francis McKeever.

4. Hugh T. Jones, Los Angeles, gave a paper, entitled "Problems Encountered in Orthopedic Care of the Knee Joint," which was discussed by Francis McKeever, R. O. Schofield, H. B. Slavin, and H. T. Jones.

5. Elmer Belt, Los Angeles, gave a paper, entitled "Obstructive Uropathy in Childhood," which was discussed by R. B. Stahr and Elmer Belt.

A vote of thanks was expressed for the splendid cooperation of the Clark County Medical Society and committee members in making the thirty-seventh meeting a success.

There being no further business the meeting adjourned at 12:50 p. m. A luncheon followed at the Apache Hotel, after which an address was given by Senator Key Pittman.

The following members were in attendance at various times during the meeting: Horace J. Brown, Gerald J. Sylvain, C. W. West, J. L. Robinson, S. K. Morrison, Morse Little, Roland W. Stahr, and Vernon Cantlon, all of Reno; J. R. McDaniel, Jr., Forest R. Mildren, Stanley L. Hardy, Karl J. Kraus, and Hale B. Slavin, all of Las Vegas; A. R. Thompson, Minden; Charles E. Secor, Elko; W. S. Sargent, Hawthorne; R. A. Bowdle, East Ely; George R. Magee, Yerington; R. O. Schofield, Sacramento; Noah Smernoff, McGill; William B. Ririe, Ruth; Gus Oredson, Kimberly; J. H. Hastings, Pioche; Robert R. Craig and Jack C. Cherry, both of Tonopah; Edward E. Hamer, F. M. Anderson, Carson City; D. J. Hurley, Eureka; Theodore H. Haun, Boulder City.

The following honorary members and guests were present at various times during the meeting: Doctors Victor Randolph, Phoenix; Elmer Belt, K. S. Davis, Verne C. Hunt, Hugh T. Jones, Francis M. McKeever, all of Los Angeles; Gerald Brown O'Connor, San Francisco; E. H. Hawkins, Austin; N. F. Hicken and L. E. Viko, both of Salt Lake City; Newton Bobbitt, Pasadena; Elmer W. Trainer and Dana D. Little, both of Boulder City; Whitfield Crane, Oakland; Z. A. D'Amours, Las Vegas; Mr. Joe Wicarius, Sacramento; Mr. Steve Richardson, Los Angeles; Mr. M. Morris Thomas, Alameda; Mr. Eugene Benjamin, Sacramento; F. J. Schneider, Los Angeles; K. P. Pattengill, Glendale; Mr. F. V. Powell, Provo; Mr. Dick Travers, San Francisco.

C. W. WEST, *President.*

HORACE J. BROWN, *Secretary.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-Five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings.†

California Medical Association, Hotel Del Monte, Del Monte, California, May 5-8, 1941.

American Medical Association, Cleveland, Ohio, June 2-6, 1941.

American College of Physicians, Statler Hotel, Boston, April 21-25, 1941.

Medical Broadcasts.*

American Medical Association Series of Radio Programs: Every Wednesday, 7:30 p. m., Pacific Time, Over Blue Network.—*Doctors at Work* is the title of the sixth annual series of dramatized radio programs to be presented by the American Medical Association and the National Broadcasting Company.

The series will open on Wednesday, November 13, 1940, and run for thirty consecutive weeks, closing with a broadcast from the American Medical Association meeting at Cleveland on June 3, 1941. The program is scheduled for 10:30 p. m., Eastern standard time (9:30, Central; 8:30, Mountain; 7:30, Pacific time) over the Blue Network, other NBC stations, and Canadian stations.

The programs will dramatize what modern medicine offers the individual in the way of opportunities for better health and the more successful treatment of disease. Incidental to this main theme, the programs will explain the characteristics of the different fields of modern medicine and its specialties.

"Doctors at Work" will be broadcast from scripts by William J. Murphy, NBC script writer and author of many previous American Medical Association and NBC "shows" and other popular radio features. It will be produced under the direction of J. Clinton Stanley, director of "Medicine in the News," last season's successful American Medical Association and NBC health program. Supervision will be by the American Medical Association Bureau of Health Education, directed by Dr. W. W. Bauer.

These programs are broadcast on what is known in radio as a sustaining basis; that is, the time is furnished gratis by the radio network and local stations and no revenue is derived from the programs. Therefore, local stations may or may not take the programs, at their discretion, except those stations which are owned and operated by the National Broadcasting Company.

The programs will dramatize what modern medicine offers the individual in the way of opportunities for better health and the more successful treatment of disease. Incidental to this main theme the programs will explain the characteristics of the different fields of modern medicine and its specialties.

The next programs to be broadcast, together with their dates and their topics, are as follows:

†In the front advertising section of *The Journal of the American Medical Association*, various rosters of national officers and organizations appear each week, each list being printed about every fourth week.

*County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

December 4—Paging Doctor Drew.

December 11—The Family's First Friend.

December 18—A Stitch in Time.

Descriptive posters for local distribution may be had gratis from the Bureau of Health Education, American Medical Association, 535 North Dearborn Street, Chicago. Program titles will be announced weekly in *The Journal of the American Medical Association*, and monthly in *Hygeia, the Health Magazine*.

American Medical Association Broadcasts: "Medicine in the News."—The American Medical Association and the National Broadcasting Company have announced "Medicine in the News," on timely topics from medical news of the week. Thursdays, 4:30 p. m., Eastern standard time (1:30 p. m., Pacific standard time), Blue Network, coast to coast. Thirty weeks. Opened on November 2, 1939. Facts, drama, entertainment, music.

Pacific States:

KECA	Los Angeles	KEX	Portland
KFSD	San Diego	KJR	Seattle
KGO	San Francisco	KTMS	Santa Barbara
	KGA	Spokane	

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Los Angeles County Medical Association.

The following is the Los Angeles County Medical Association's radio broadcast schedule for the month of December, 1940:

Saturday, December 7—KFI, 9:45 a. m., The Road of Health.
 Saturday, December 7—KFAC, 10:15 a. m., Your Doctor and You.
 Saturday, December 14—KFI, 9:45 a. m., The Road of Health.
 Saturday, December 14—KFAC, 10:15 a. m., Your Doctor and You.
 Saturday, December 21—KFI, 9:45 a. m., The Road of Health.
 Saturday, December 21—KFAC, 10:15 a. m., Your Doctor and You.
 Saturday, December 28—KFI, 9:45 a. m., The Road of Health.
 Saturday, December 28—KFAC, 10:15 a. m., Your Doctor and You.

California State Chamber of Commerce: Mineral Springs Section.—Leaders of industrial, agricultural and civic affairs representing every county of California will assemble in Los Angeles, December 5 and 6, for the fifteenth annual state-wide meeting of the California State Chamber of Commerce.

An attendance of more than 1,000 members of the Chamber's six regional councils, its various committees, and federal, state, and local government officials, is expected for the two-day conference.

In the call for the meeting, A. J. Lundberg, president of the State Chamber, emphasized the urgent nature of the problems now confronting California and all of America in the present national emergency, and the need for organized and united efforts.

California Medical Association has been requested to send a representative to speak on Mineral Springs, of which there are many in the State. The Association Secretary, George H. Kress, has been designated to give this talk.

An Estimate Concerning Office Expenses of Physicians.—Of every dollar collected by the average American physician from his patients, 40 cents is paid out in the form of rent, secretarial salaries, automobile upkeep, drugs, supplies, equipment, and other professional expenses, according to reports received from 7,707 physicians by *Medical Economics*.

California Health and Safety Code: Re Infectious Diseases.—Attention is called to Section 7404: Chapter 6, of the Health and Safety Code of the State of California (1939) which states:

"If death occurred from any disease held by the State Department to be infectious, contagious or communicable and dangerous to public health, the body shall not be removed without first securing permission of the local health officer." (Amended by Stats. 1930, Chap. 101.)

The hasty fixing of tissues; for example, the brain and spinal cord may make virus studies impossible, or there is always the possibility that the embalming of a body before the diagnosis can be confirmed by the laboratory may lead to serious consequences.

Some Valuable Tips for Physicians Doing Radio Broadcasting.—In as much as physicians are being called upon more and more to do radio broadcasting, the following excerpt from a bulletin issued by the Columbia Broadcasting Company is especially timely and its recommendations should be heeded by all physicians when called upon to speak over the air:

"Effective radio speakers realize that they hold or lose the listener in the first minute or two. Therefore, they make a point of doing these things:

"They select a subject interesting, important and vital to people.

"They find out what interests people by asking those who really represent different sections of the radio audience—such as the business man, the manufacturer, the scientist, the teacher, the young student, the man in the street, the laborer, the motorman, the clerk, and so on.

"They write as they talk.

"They make their talk alive with things of homely interest.

"They make their remarks short, terse, and direct to the point.

"They make their speech concrete and specific about a few points. They know that too many ideas confuse the listener.

"They write their speech so as not to crowd the time allotted. They allow themselves ample time for emphasis; for using a free and easy manner without galloping to a finish.

"They use simple, understandable words which every listener knows. They realize it is unnecessary to impress on the listener that they know all the big words in the dictionary.

"They avoid long, pedantic speeches.

"They avoid statistics as they would the plague. If statistics are unavoidable, similes by word pictures are always best.

"They avoid humor, unless they are qualified to use it. They know that it takes a natural humorist to tell a funny story.

"They never make the direct statement that they are going to prove so and so. They know that this always makes a listener antagonistic.

"They approach the microphone as if they were discussing matters with a group of acquaintances.

"They speak sincerely and convincingly.

"They pace their talk as they would in face-to-face conversation. They always avail themselves of time for studio rehearsals at the broadcasting station.

"They follow the meaning of their remarks, rather than the actual commas and periods.

"They time their speech at rehearsal, and they carefully watch their time.

"They leave their audience wanting more.

"They broadcast as they talk, not as they read.

"They do not clear their throats or cough when near a microphone. They have their manuscripts on loose sheets, never clipped together. They know that in this way they can drop each sheet to the floor as it is finished.

"They never say anything for a few seconds before starting or after closing. They are conscious that the microphone might be open and pick up such sounds."

New Position: Assistant Chief of Laboratories, California State Board of Public Health.—Applications for a new position, "Assistant Chief of Laboratories," must be mailed prior to midnight, December 14, 1940, to California State Personnel Board, 1025 P Street, Sacramento. Headquarters of position will be at Berkeley. Entrance salary, \$275 per month. Personnel Board information concerning the position has been mailed to San Francisco and Los Angeles County Medical Associations, for placement on their bulletin boards. Addresses of the Sacramento, San Francisco and Los Angeles offices of State Board of Health appear in each issue of *CALIFORNIA AND WESTERN MEDICINE*, on advertising page 6.

Australian Q Fever.—Australian Q fever germs have been found responsible for an epidemic during the early part of this year of what appeared to be influenza or a strange type of pneumonia, according to findings announced recently by the United States Public Health Service. (*Public Health Reports*, Vol. 55, No. 43.)

This epidemic attacked fifteen employees at the National Institute of Health, in Washington, D. C., one of whom died. Upon investigation it has been found that the rickettsia which causes Q fever in Australia was present in at least three of the cases.

Q fever was first described in Australia in 1937. Work on this particular rickettsial disease has been in progress at the National Institute of Health since the spring of 1938. . . .

American Board of Obstetrics and Gynecology: Examination.—The written examination and review of case histories (Part I) for Group B candidates will be held in the various cities of the United States and Canada on Saturday, January 4, 1941, at 2 p. m. Formal notice of the place of examination will be sent each candidate several weeks in advance of the examination date. No candidate will be admitted to examination whose examination fee has not been paid at the secretary's office. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination to be held in June, 1941.

For further information and application blanks, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Informal Bulletin.—From time to time, Chauncey D. Leake, of the Department of Pharmacology of the University of California Medical School, sends to associates and others who may be interested, a mimeographed sheet partaking of the nature of an informal bulletin. From a recent specimen, the following excerpts:

Calling attention to: An occasional bulletin of ideas, chiefly pharmacological, which may be of interest to clinicians of the University of California Medical School.

1. *Scientific journals* from continental European countries have practically ceased to arrive since last July. An occasional German or Italian issue comes by way of Siberia. So far there has been no significant delay in receipt of English, Asiatic, or South American periodicals. Prompt air mail delivery continues to occur for letters from Holland and Switzerland. Scientific laboratories in these countries seem to be functioning. Not so, however, in France or Belgium.

Other subheadings include:

2. *Hot new work in chemotherapy.*

3. *The Proceedings of the American Society of Clinical Investigation* appears in the September issue of the "*Journal of Clinical Investigation*," 19:765, 1940.

4. *Chronic arsenic poisoning.*

5. *New books.* An ornate, back-scratching, and slightly naïve volume records the proceedings of the Dental Centennial celebration, Baltimore, 1940. Another slightly naïve item is the "silver anniversary" issue of the *Journal of Laboratory and Clinical Medicine*.

6. *Odds and ends.*

Association of California Hospitals.—The 1940 mid-year meeting of the Association of California Hospitals (State of California Unit of the American Hospital Association) was held on November 9 and 10, 1940, at the Fresno Hotel, Fresno.

Program follows:

Saturday, November 9, 1940

9:00 a. m.—Registration.

9:15 to 10:15 a. m.—General Business Session.

Glenn E. Myers, M. D., President, Association of California Hospitals, Presiding

Invocation—Right Reverend Monsignor Thomas J. O'Dwyer, Catholic Welfare Bureau, Los Angeles.

President's Report—Glenn E. Myers, M. D.

Council Reports:

Council on Administrative Practice

D. L. Braskamp, Chairman, Alhambra Hospital, Alhambra.

Council on Association Development

W. L. Krell, Chairman, Mills Memorial Hospital, San Mateo.

Council on Government Relations

William P. Butler, Chairman, San Jose Hospital, San Jose.

Council on Planning and Plant Operation

Ralph Hromadka, Chairman, Santa Monica Hospital, Santa Monica.

Council on Professional Practice

Rev. Richard T. Howley, Chairman, Catholic Charities, San Francisco.

Council on Public Education

C. E. Nelson, M. D., Chairman, Paradise Valley Sanitarium and Hospital, National City.

Treasurer's Report—A. E. Maffly, Berkeley Hospital, Berkeley.

10:30 to 11:45 a. m.—Round-Table Discussion.

Glenn E. Myers, M. D., President, Association of California Hospitals, Presiding

Subjects and Speakers:

Los Angeles Plan of Infant Identification—Ritz E. Heerman, Superintendent, California Hospital, Los Angeles.

The Basis of Hospital Rates for Industrial Compensation Cases—Paul C. Elliott, Superintendent, Hollywood Hospital, Los Angeles.

The Value of Annual Safety Inspection: A Review of Precautions Hospitals Should Employ as Safeguards Against Accidents—J. V. Buck, Superintendent, Hospital for Children, San Francisco.

Control and Handling of Narcotics in Hospitals—George U. Wood, Administrator, Peralta Hospital, Oakland.

12 noon to 1:30 p. m.—Luncheon.

Luncheon Speaker: Ways and Means of Reducing Compensation Insurance—J. V. Buck, Superintendent, Hospital for Children, San Francisco.

1:30 to 4:30 p. m.—Legislative Session.

William P. Butler, Chairman, Council on Government Relations, Presiding

Subjects and Speakers:

Should Hospitals Be Inspected and Licensed Under State Law?—Raymond D. Brisbane, Superintendent, Sutter Hospital, Sacramento; O. N. Anderson, M. D., General Director, School of Hygiene and Physical Education, Stanford University.

A Proposed Lien Law—Ritz E. Heerman, Superintendent, California Hospital, Los Angeles; Reginald Moss, Managing Director, Association of Casualty and Surety Executives, San Francisco.

Hospital Reimbursement Law—Sister M. Liguori, Chairman, Legislative Committee, Western Conference, Catholic Hospital Association; Hugh M. Burns, Assemblyman, Fresno County.

Exemption of Hospitals from Liability Arising from Negligent Acts of Employees—Howard Burrell, Attorney for Association of California Hospitals, Los Angeles; Ellard L. Slack, Superintendent, Samuel Merritt Hospital, Oakland.

New and Proposed Medical Legislation from the Standpoint of the Medical Profession—George H. Kress, M. D., Secretary, California Medical Association.

Summary—William P. Butler.

6:30 p. m.—Dinner Meeting.

7:30 to 9:00 p. m.—Round-Table Discussion.

Subjects and Speakers:

Some Problems Creating the Demands for the Open County Hospital—Right Reverend Monsignor Thomas J. O'Dwyer, Catholic Welfare Bureau, Los Angeles.

Reciprocal Agreement Between the County Hospital and the Voluntary Hospital—Leo W. Farrell, M. D., Medical Director, Sacramento County Hospital, Sacramento.

Extension of the Group Hospitalization Plan to the Farm Bureau—W. E. Mitchell, M. D., Oakland.

The Responsibility of the Voluntary Hospital for the Part-Pay Patient—L. Louise Baker, R. N., Superintendent, Santa Barbara Cottage Hospital, Santa Barbara.

Sunday, November 10, 1940

10:00 to 11:30 a. m.—Nursing Session.

Glenn E. Myers, M. D., President, Association of California Hospitals, Presiding

Subjects and Speakers:

Some Reasons Hospitals Face Difficulties in Obtaining General Duty Nurses—Jean Barthe, R. N., Placement Committee, California State Nurses' Association, Oakland.

What the California State Nurses' Association Is Doing to Meet the Existing Shortage of Nurses—Stella M. Freidinger, R. N., Assistant Director, California State Nurses' Association.

Are More Schools of Nursing Needed to Meet the Demand for Registered Nurses? Are Larger Classes in Nursing Schools the Answer?—Sister Elizabeth Clare, R. N., President, Western Conference, Catholic Hospital Association, Providence Hospital, Oakland.

The Registration of Nurses Under the Nurse Practice Act—Mildred Newton, R. N., Assistant Professor of Nursing, University of California School of Nursing, San Francisco.

Suggested Outline of Duties of Orderlies and Nursing Aids Supplementing the Nursing Service in the Hospital—Gertrude R. Folendorf, R. N., Superintendent of Shriners' Hospital for Crippled Children, San Francisco.

Training Attendants Under the Trained Attendants Act—Andrew C. Jensen, Superintendent, Fairmont Hospital, San Leandro.

11:35 a. m. to 12:30 p. m.—Round-Table on Nursing Problems.

A. J. J. Rourke, M. D., Superintendent, Stanford University Hospital, San Francisco, Presiding

Subjects:

Are Hospitals Employing Non-Licensed Nurses Violating the Nurse Practice Act?

Should Hospitals Employ Nursing Aids to Supplement the Nursing Service?

What Are the Reasons for the Increasing Difficulty of Small Hospitals Obtaining Adequate Registered Nurse Personnel?

Is the Eight-Hour Day for Nurses in Effect Throughout the State of California?

What Is Considered the Minimum Standard of Wages and Employment Conditions for Nurses?

Should Present Three-Year Course Be Revised, Placing Emphasis on Training for General Duty Nursing?

Discussion Leaders—A. E. Hodgeman, Superintendent of Fraser Hall, San Diego; Miss Jean Barthe, R. N., Placement Committee, California State Nurses' Association, Oakland; Miss Jennie Gardiner, R. N., Chairman, Legislative Committee, California State Nurses' Association.

Adjournment, 12:30 p. m.

Hospital Conferences Affiliated with the Association of California Hospitals

Central Coast Hospital Conference: President, W. L. Krell, Manager, Mills Memorial Hospital, San Mateo; Secretary, Miss K. Smits, R. N., Superintendent, Peninsula Community Hospital, Carmel.

East Bay Hospital Conference: President, Alfred E. Maffly, Superintendent, Berkeley Hospital, Berkeley; Secretary, John S. Rafter, Superintendent, Richmond Hospital, Richmond.

North San Joaquin Hospital Conference: President, Clara McKibben, Dameron Hospital, Stockton; Secretary, J. L. Mudd, M. D., Merced.

South San Joaquin Hospital Conference: President, D. O. Bean, Superintendent, Hanford Sanitarium, Hanford; Secretary, Sister M. Alfreda, Superintendent, St. Agnes Hospital, Fresno.

Redwood Empire Hospital Conference: President, E. D. Barnett, M. D., Medical Director, Sonoma County Hospital, Santa Rosa; Secretary, Miss Ena M. Bunt, Superintendent, Ross General Hospital, Ross.

San Francisco Hospital Conference: Chairman, V. W. Olney, Superintendent, St. Francis Hospital, San Francisco; Secretary, Howard B. Hatfield, Business Manager, St. Luke's Hospital, San Francisco.

Hospital Council of Southern California: President, Mary K. West, R. N., Superintendent, Methodist Hospital, Los Angeles; Secretary, Ritz E. Heerman, Superintendent, California Hospital, Los Angeles.

American Public Health Association.—The registered attendance at the sixty-ninth annual meeting of the American Public Health Association and meetings of related organizations held in Detroit the week of October 7 was 3,187, second largest in the association's history. Delegates came from every state in the Union, the District of Columbia, Alaska, Hawaii, Puerto Rico, Canada, Cuba, Mexico, Denmark, China and New Zealand.

Among the resolutions passed was one emphasizing the necessity for maintaining civilian health as essential in national defense and pledging the united support of members to the national defense and to the maintenance of health in a free people.

The seventieth annual meeting will be held in Atlantic City, New Jersey, in October, 1941.

Owners and Locations of Respirators in California.—In order that local health officers and public health workers may have a ready reference to the availability of respirators, which may be needed in emergencies, a list of the owners and locations of respirators in California is published herewith.

Arlington—Riverside Hospital.
 Bakersfield—Kern County General Hospital (two).
 Berkeley—General Hospital.
 Carmel—Peninsula Community Hospital.
 Daly City—Villa Hospital.
 El Centro—Imperial County Hospital.
 Eureka—Humboldt County Hospital.
 Fresno—Fresno County Hospital, General Hospital.
 Hanford—Kings County Hospital, Kings County Nurses' Association, Dr. J. A. Crawshaw.
 Long Beach—Seaside Hospital.
 Los Angeles—Children's Hospital, County General Hospital.
 Martinez—County Hospital (four).
 Monterey—Monterey Hospital.
 Oakland—Children's Hospital (two), Highland Hospital.
 Orange—Orange County Hospital.
 Palo Alto—Palo Alto Hospital.
 Pasadena—Pasadena Hospital.
 Sacramento—Sacramento County Hospital, Sutter Hospital.
 Salinas—County Hospital.
 San Bernardino—The Argonauts Breakfast Club (for county).
 San Diego—Mercy Hospital, Naval Hospital, San Diego County Chapter of the National Foundation for Infantile Paralysis, Inc. (at San Diego County General Hospital), San Diego County General Hospital.
 San Francisco—Children's Hospital (three), Emergency Hospital, Letterman General Hospital, Mount Zion Hospital, San Francisco Hospital (three), Stanford University Hospital (two), University of California Hospital (two).
 San Jose—O'Connor Sanitarium, San Jose Hospital.
 San Mateo—Mills Memorial Hospital.
 Santa Barbara—St. Francis Hospital.
 Stockton—San Joaquin County Hospital.
 Tulare—Tulare County Hospital.

Society of Medical Friends of Wine.—In order to study wine growing at first hand, fifty-four Northern California physicians visited some of the historic vineyards and wine cellars of the Napa Valley October 13 on a Vintage Tour sponsored by the Society of Medical Friends of Wine.

The doctors viewed the harvesting of grapes in the vineyards, their pressing at the wineries, and the fermentation of the must into wine. They visited four wine cellars and tested various wines. At noon they tasted additional wines of the district at a luncheon at St. Gothard's Inn.

The Society of Medical Friends of Wine was organized in 1939 to stimulate scientific research of wine, develop an understanding of its beneficial effects, and encourage an appreciation of the conviviality and good fellowship that are a part of the relaxed and deliberate manner of good living that follows its proper use.

The Society holds quarterly dinner meetings, and now plans to add an annual vintage tour to the vineyards.

The officers of the Society are: Thomas F. Mullen, president; M. A. Francoz, vice-president; Randolph G.

Flood, secretary; H. E. Alderson, treasurer. Pioneers of the society are: H. E. Alderson, R. E. Ashley, Lloyd Crow, M. A. Francoz, C. D. Leake, S. P. Lucia, C. P. Mathé, H. C. Moffitt, T. F. Mullen, Langley Porter, R. A. Yoell, and G. E. Ebright.

Revised List of Reportable Diseases in California.—The California State Board of Public Health has recently revised, by regulation, the list of diseases that are reportable in California. The following diseases have been removed from the list of diseases that are reportable only: beriberi, chancroid, fluke infection, hookworm, and pellagra.

The term "lymphogranuloma inguinale" has been changed to "granuloma inguinale" and the disease is made reportable and subject to isolation. Epidemic dysentery of the newborn (in institutions) has been made reportable and subject to isolation. Lymphopathia venereum has also been added to the list of diseases that are reportable and subject to isolation. Erysipelas has been removed from the list of reportable diseases.

Following is a list of diseases reportable in California, classified according to control methods, reportable only, subject to isolation, and subject to quarantine and placarding:

List of Diseases Reportable in California

1. Reportable Only:

Anthrax
 Botulism. If commercial product, notify State Department of Health at once.
 Coccidioidial granuloma
 Dengue. Keep patient in mosquito-free room.
 Epilepsy
 Food poisoning
 Glanders. Report by phone or telegraph.
 Jaundice—infectious or epidemic types.
 Malaria. Keep patient in mosquito-free room.
 Pneumonia. Specify type of pneumococcus, if known.
 Relapsing fever
 Rocky mountain spotted fever
 Tetanus
 Trichinosis
 Tularemia
 Undulant fever

2. Reportable and Subject to Isolation:

Epidemic diarrhea of the newborn (in institutions)
 Chickenpox
 Dysentery—Amebic
 Dysentery—Bacillary. Specify type, if known.
 German measles
 Influenza
 Measles
 Mumps
 Ophthalmia neonatorum
 Psittacosis
 Rabies—in animals. Use special card.
 Rabies—in humans.
 Septic sore throat (in epidemic form).
 Trachoma
 Tuberculosis. Use special card.
 Whooping cough
 Syphilis. Use special card.
 Gonorrhea. Use special card.
 Chancroid. Use special card.
 Lymphopathia venereum. Use special card.
 Granuloma inguinale. Use special card.

3. Reportable and Subject to Quarantine and Placarding:

Cholera. Report by telephone or telegraph to State Department of Health.
 Diphtheria
 Encephalitis (infectious). Specify type, if known.
 NOTE: This means all forms of acute encephalitis, such as St. Louis type, equine type, and any other epidemic form occurring in California.

Leprosy
 Meningitis (due to the meningococcus).
 Paratyphoid fever. Specify type A or B.
 Plague. Report by telephone or telegraph to State Department of Health.
 Acute anterior poliomyelitis
 Scarlet fever
 Smallpox
 Typhoid fever
 Typhus fever
 Yellow fever. Report by telephone or telegraph to State Department of Health.

American Academy of Dermatology and Syphilology. Over 600 dermatologists from all parts of the United States and Canada are expected to go to Chicago for the third annual meeting of the American Academy of Dermatology and Syphilology at the Palmer House, December 8, 9, 10, and 11. Over sixty lectures are listed on the program from Monday, December 9, through Wednesday, December 11. Sessions are in the form of symposia, special lectures in courses of one to four hours each; numerous luncheon round table discussions, and clinical presentations at the University of Illinois Medical School in Chicago.

Army Sick List Here Checked for Possible Influenza Epidemic.—With approximately 150 patients with respiratory infections under treatment at Letterman General Hospital, Bay Area health authorities today were closely watching the possible development of an influenza epidemic. The influx of patients, all from local military posts, started November 13, and has now reached proportions of a "low epidemic," Letterman Hospital authorities said.

Medical authorities, however, were not surprised at the appearance of the disease as they had been warned to expect it by Dr. M. D. Eaton, chief of the influenza laboratory of the University of California.

"I was in the Hawaiian Islands in October watching the influenza epidemic," Doctor Eaton said. "I warned mainland health authorities that it might be carried eastward by passengers or troops. The epidemic is now under control in Honolulu, but is still serious in the outlying islands."

Another week or ten days will be needed to complete laboratory tests to ascertain if the infections being treated at Letterman are influenza, Doctor Eaton indicated.

Close watch kept over troops' health and the concentration of all ill men from the Bay Area in one hospital explains the sudden jump of cases at Letterman, medical authorities said.—*San Francisco News*, November 22.

Control of Venereal Diseases in California: Co-operation of Druggists.—Cooperation of druggists is proving a vital factor in the control of venereal diseases in California, Dr. Bertram P. Brown, state health director, reports.

Hundreds of patients have been referred to doctors and clinics since the State Department of Public Health began its voluntary program of cooperation.

Started in Alameda County in February, the program has been completed in the following counties: Contra Costa, Imperial, Nevada, Sacramento, San Diego, San Joaquin, Sonoma, Sutter, and Yuba. It is nearing completion in Los Angeles County.

Pledges of cooperation had been made by 1,280 druggists up to November 1. Only eleven firms had refused to sign the pledge that they "will not sell medicines for the treatment of venereal diseases except upon order of a physician's prescription and will refer all patients to a physician or to a health clinic."

In response to a questionnaire, physicians in Alameda County reported that 122 patients had been referred to them by druggists since the educational program was concluded there. The Oakland city clinic reported it had admitted 105 patients referred by druggists during the same period.

Press Clippings.—Some news items from the daily press on matters related to medical practice follow:

Medical Group Backs Low-Cost Housing Program
Governors Approve Recommendation of City Health Officer

The Board of Governors of the Fresno County Medical Society, through a letter from Dr. J. E. Young, secretary, today informed Mayor Frank A. Homan of its endorsement of a recommendation by Dr. Carleton Mathewson, City Health Officer, favoring the proposed \$738,000 slum clear-

ance program offered the city by the United States Housing Authority. . . .

In Doctor Young's communication, the minutes of the special board meeting are enclosed, saying, in part:

"It was moved by Dr. H. A. Randel and seconded by Dr. J. M. Frawley that the Board of Governors of the Fresno County Medical Society go on record as endorsing the recommendations of the Fresno City Health Officer regarding the slum clearance program for Fresno as sponsored by the United States Housing Authority. . . ."

Doctor Young added in his letter the statement that "it is the attitude of the Board of Governors and of the members of the Fresno County Medical Society that it does not wish to take any stand upon any controversial political subjects, but it is definitely in favor of any program that will help to improve the health of this city." . . .

According to Doctor Young the Board's actions have the sanction of the Society membership, which includes most of the physicians and surgeons in Fresno and Madera counties. . . .—*Fresno Bee*, October 24, 1940.

* * *

150,362,326 Now in U. S. Family

Population Figures Include Territories and Possessions

Washington, Nov. 19 (AP).—The Census Bureau today placed the total population of the United States, its territories and possessions at 150,362,326.

This represented an increase of 11,923,267, or 8.6 per cent, over the 1930 census, on the basis of preliminary figures. . . .

The continental United States population previously had been placed at 131,409,881, an increase of 7 per cent. The population of territories and possessions, excluding the Philippine Islands, was placed at 2,596,445, a gain of 445,422, or 20.7 per cent. . . .—*San Francisco Chronicle*, November 20, 1940.

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San Francisco Municipal Employees Reassured on No. 8

Assurance has been given municipal employees that the San Francisco medical profession has no intention of "taking over" the Employees' Health Service System nor of seeking increased financial contributions from System members.

The assurance was given by Dr. John W. Cline, chairman of the Health and Hospitalization Insurance Committee of the San Francisco County Medical Society.

In a letter to the Health Service Board, which administers the employees' group health insurance program, Doctor Cline asked Board cooperation in dispelling two misunderstandings encountered among city workers during the recent Charter Amendment No. 8 campaign.

"One was that Charter Amendment No. 8 is an entering wedge for doctors to take over the System; another was that No. 8 was sponsored by the Society to lay the groundwork for demanding an increase in members' contributions," said Doctor Cline.

Since Charter Amendment No. 8 takes nothing from the Health Service Board's powers, it cannot be an "entering wedge" to take over the System, Doctor Cline pointed out. Equally, the amendment has not effect on members' contributions, he said. Doctor Cline continued:

"Actually, Charter Amendment No. 8 provides for an annual review of the adequacy of medical care furnished System members and of compensation paid for such care, with power of review vested in the Retirement Board. As such it is in the interests alike of System members and those who serve them and was so conceived."—*San Francisco Recorder*, November 12, 1940.

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New Appointment to Medical Board

Los Angeles, Nov. 13 (AP).—Governor Olson announced today the appointment of Dr. Hugo N. Kersten, Los Angeles physician, to the State Board of Medical Examiners, and the reappointment of Dr. Charles B. Pinkham of San Francisco.

Doctor Kersten succeeds Dr. William R. Molony of Los Angeles, whose term expired last January 15.—*San Francisco Chronicle*.

* * *

Medical Board Member Resigns

Examiner Bureau, Sacramento, Nov. 20.—The Governor's office today announced receipt of the resignation of Dr. C. E. Schoff of Sacramento from the State Board of Medical Examiners.

A member of the Board since 1919, Doctor Schoff resigned a term expiring January 15 for "personal reasons," officials said.—*San Francisco Examiner*.

* * *

Ponder Legislation

The Legislative Committee of the San Francisco Life Underwriters Association, headed by James M. Hamill of the Equitable Life of New York and the Committee of the California State Association of Life Underwriters are pon-

dering a number of proposed legislative measures affecting the life insurance business. . . .

Another measure in which both the life and the accident and health underwriters are interested sets up a legal status for voluntary hospital insurance associations with definite requirements. It would regulate doctors and hospitals seeking to render such service for regular monthly or annual fees and place them upon an insurance company basis as far as State regulation and supervision is concerned.—San Francisco *Commercial News*, November 4, 1940.

* * *

Cyclotron Aids Fight on Disease

U. C. Scientists Report Progress in Cancer, Leukemia Studies

Eight University of California scientists held the center of interest at Cambridge, Mass., yesterday with reports to the National Conference on Applied Nuclear Physics of the latest work done with Dr. Ernest O. Lawrence's atom-smashing cyclotron.

In four papers read to the conference they announced these developments:

1. To date seventy-five cancer sufferers have been treated with the strange neutron ray created by the cyclotron, with results that justify continued experiment.

2. Sixteen victims of chronic leukemia have been treated with "cocktails" containing radioactive phosphorus produced in the cyclotron, and results in eleven cases are "quite encouraging."

3. Tiny organisms, so small they must be put under the microscope to be seen, are being put to work in a novel manner to produce radioactive acids which cannot be synthesized in the laboratory.

4. As a result of findings on the danger to workers from rays produced by the cyclotron, the projected 4,900-ton cyclotron will be surrounded by a wall of water 20 feet thick, with the control room underground or over the brow of the hill.

Cancer Treatment

Reporting on the cancer treatment were Dr. Robert S. Stone and Dr. John C. Larkin, staff members at the radiation laboratory and medical school.

Because a cancer patient must be well for at least five years after his apparent cure before he can be considered cured, the doctors said it is "much too early" to speculate on the worth of the new neutron treatment.

They said, however, that "early effects are encouraging."

In their report on the leukemia treatments, Drs. John Lawrence, L. A. Erf and L. W. Tuttle said that radioactive phosphorus is found to go naturally to those parts of the body where the excessive white blood cells of leukemia are manufactured.

Administered in liquid solutions, dubbed "cocktails" by some of the experimenters, the phosphorus radiations seem able to destroy diseased tissue without injuring normal body cells, said the report.

Radioactive Acid

Drs. Samuel Ruben and Martin D. Kamen, the laboratory's specialists in biochemical fields, reported that they successfully "fed" radioactive carbon to microorganisms, and the organisms in turn produced an acid which the scientists wanted.

The radio activity of the carbon was preserved in the acid, making the acid suitable for experiments which the scientists wish to make on functions of the human body.

Dr. Paul C. Aebersold, reporting on studies made of the effect of radiations within the laboratory on laboratory workers, said his findings will lead to several protective measures at the big laboratory being built in Strawberry Canyon at Berkeley for the new cyclotron.

Thick Walls

There will be thick walls of concrete around all working quarters, and workers will stay 30 feet away from the cyclotron, he said.

Doctor Aebersold disclosed that laboratory workers regularly undergo examinations to make certain they are not absorbing too much of the neutron and gamma rays.

When a worker is absorbing too much radiation he takes a few days off.—San Francisco *Examiner*, November 1.

* * *

Trophy Goes to Physicians

Three Given Collier Award for Research in Stratosphere

Washington, Nov. 14 (AP).—One of the nation's outstanding awards for achievement in aviation today went to three physicians who pioneered in studying why a pilot's blood boils when he ascends to a height of seven miles above the earth.

Dr. Walter Boothby and Dr. W. Randolph Lovelace II of the Mayo Clinic, Rochester, Minn., and Capt. Harry Armstrong of the Army Medical Corps were awarded the Col-

lier Trophy, presented annually since 1911, for their medical research work on what happens to a person's brain, nerves, blood and reflexes when he ascends into the stratosphere.

Cause of Accidents

They have found that a flyer loses consciousness almost instantly if he falls to keep breathing oxygen when he goes above 20,000 feet, that many accidents are caused by anoxemia—oxygen want—that a pilot cannot coordinate his muscles without sufficient oxygen to feed them.

They would scoff at being called courageous because, to them, it is just part of the day's work.

Yet Captain Armstrong has taken off his oxygen mask at 35,000 feet on numerous occasions ("just to see what would happen") and promptly was "blacked out" until he dropped to 20,000 feet.

Done Repeatedly

Doctor Boothby and Doctor Lovelace, with the same inquisitiveness, have done the same thing repeatedly in the air and in the low-pressure chamber of the Mayo Clinic and the Army Air Corps at the Wright Field Matériel Division in Dayton, Ohio.

They have proved that actually a man's blood does boil when he gets into the rarefied atmosphere five miles or more aloft, that a pilot becomes extremely fearful when he suffers from lack of oxygen for less than a minute, that he cannot coordinate his brain and muscles. He thinks he thinks, but doesn't.

Give Others Credit

The three physicians give most of the credit for the award to the pilots of Northwest Airlines, who acted as guinea pigs in extensive tests in the Mayo Clinic's low-pressure chamber; to D. W. Tomlinson, research pilot of Transcontinental and Western Air; to several hundred Rochester high school boys who did "fatigue" tests on the Mayo Clinic treadmill; to the men of the Army Air Corps who made standardization of pressure reactions possible, and particularly to a young self-effacing private named Raymond Whitney of the Matériel Division at Wright Field, Dayton, Ohio.—Los Angeles *Times*.

* * *

Some Motorists Can Drink and Still Drive Well

San Francisco, Nov. 7.—Scientific evidence that some people can toss off five or six drinks of liquor in 15 minutes and still handle the steering wheel and brakes of an automobile better than certain others who are cold sober, was reported yesterday by two California researchers.

Drinking, they said, undoubtedly lowers driving efficiency. But they found that while a given amount of alcohol in the blood, for instance, enough to make the average person unsteady, might make some unfit to sit behind the wheel, it had no significant effect on the driving efficiency of many others.

They concluded there were no scientific grounds for setting a definite figure on alcohol in the blood as a yardstick for intoxication; that one might just as well use a person's height rather than a pair of scales to determine his weight.

The report was made by Dr. Henry Newman, neuropsychiatrist at Stanford University Medical School, and Edwin Fletcher of the State Motor Vehicle Department to the *Journal of the American Medical Association*.—Colusa *Sun-Herald*.

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Greatest State Fair Closes

New Attendance Mark of 700,000 Established at Eleven-Day Exhibition

Sacramento (Associated Press).—Thousands joined the chorus, "Happy Birthday!" for California today and helped the State Fair celebrate the last of eleven record-breaking days.

The fair came to a festive finish with an Admission Day program highlighted by a "parade of pioneers" and an old-fiddlers' contest.

It left behind a new attendance mark of at least 700,000, a \$500,000 race-track handle, awards of \$150,000 in premiums and \$10,000 in varied exhibits.

Preparing for Next

Preparing already for the 1941 exposition, the Board of Directors set August 29 to September 7 as the dates of next year's show. . . .—Los Angeles *Times*, September 10.

* * *

A Burden on Society

Editor of *The Bee*—Sir: For the fiscal year ending June 30, 1937, New Jersey appropriated \$15,037,382.17 to care for her social inadequates. That was nearly fifteen times the amount provided for higher education. During the biennium, 1935-36, New Jersey spent \$10,094,340 for new plant and equipment for these inadequates. In spite of these vast

sums not over 10 per cent of those receiving it are under institutional care at any one time. The 90 per cent are at liberty to mingle in society and reproduce their kind.

Many of the idiots and imbeciles are so low in the scale of intelligence they do not constitute much of a problem in reproduction. Morons and feeble-minded are just the reverse. Some of these of higher grade can pass as normal, and mingle in society. With low inhibitions, they are a menace to society. Particularly is this true when they contact the females of their own mental class.

It has been said that an insane person may produce a genius, but not so with the feeble-minded. Their offspring are always below par mentally, and are more prolific than the normal individual. They are largely responsible for our social problem.

Yours for a program of eugenics sterilization of the feeble-minded.—Dr. Eugene H. Pitts, Sacramento, November 2, 1940.—Sacramento Bee, November 4.

Control Plan Is Working

Editor of *The Bee*—Sir: An incident on this trip is illuminating as illustrating progress in disease control. It also will awaken memories of older Sacramentans.

This trip is being devoted partly to studies of the origins of the Arkie-Oakie migration into California from the Dust Bowls; partly to studies of the causes of poverty. It has included conferences with physicians in one of the foremost medical centers of the South. One of its leaders spoke most encouragingly of the ever-bettered control of venereal disease. He said formerly venereal disease was a most pressing problem. It is becoming so rare that in certain forms the young doctors hardly recognize it.

The cause and effect thereof has roots in Sacramento. Dr. Wm. F. Snow, former Sacramentan and former secretary of the California State Board of Health, planned this campaign so efficiently he was called to New York where, for some thirty years, in American Social Hygiene Organization, he has directed it. Mention also should be made of Dr. E. H. Pitts. For a long time he gave lunch hour talks on venereal disease wherever Sacramento men would listen—in the Southern Pacific Shops, the Y.M.C.A., etc. This took rare courage for there was then a social taboo on any mention of venereal disease. It was the work of a devoted few, like Doctor Pitts, in each of our forty-eight states which has built up public opinion until venereal disease is disappearing like smallpox, malaria, typhoid.

This letter is sent because *The Bee* publishes occasional letters on eugenics from Doctor Pitts. His labors, unselfish, in eugenics, may prove even more fruitful than in venereal disease control.—C. M. Goethe, Little Rock, Arkansas, October 30, 1940.—Sacramento Bee, November 5.

State Given \$37,002,500 Security Aid

Washington (AP). — California received \$37,002,500 in Federal grants during the past fiscal year to aid in financing various Social Security programs, the Social Security Board reported.

Grants to the State in the preceding fiscal year were \$27,347,000.

Included in the grants for the past fiscal year were \$27,964,600 for old-age assistance, \$2,662,400 for aid to dependent children, \$1,530,600 for aid to the blind, \$4,155,900 for unemployment compensation administration, \$333,800 for public health work, \$135,900 for maternal and child-health services, \$153,100 for services to crippled children, and \$66,300 for child welfare services.

\$42,930,200 Aid Taxes

California employers and employees paid \$42,930,200 in Social Security taxes to the Federal Government during the fiscal year. These included insurance contributions totaling \$37,384,700 paid by employers and employees, and unemployment taxes amounting to \$5,545,500 paid by employers.

From the time the Social Security Act went into operation until June 30 of this year, California's employers and employees paid \$114,095,900 in insurance contributions and the State's employers paid \$16,305,100 in unemployment taxes, making a total of \$130,400,900.

The State had a \$153,752,000 balance in its Federal unemployment trust fund account at the close of the fiscal year, June 30.

All Communities Active in 34th Annual Christmas Seal Sale

Sixty-two local tuberculosis associations in California are winding up the work of preparation for the annual Seal Sale. Coöperating with the officers and committees of these associations are thousands of willing helpers recruited from women's clubs, boys' clubs, girls' clubs, firemen, churches, welfare and civic groups, since the Christmas Seal Sale is a community affair and everybody is working.

This *News Letter* is full of timely items from all corners of the State concerning tuberculosis control work going on, and we have little space to tell of details of the Seal Sale work. However, you get an idea when we tell you that this year 178,000,000 Seals have been sold to the local associations and these will be resold to finance the work of the year's program. This is a million more Seals than have ever been sold in California. During the past month 936 boxes and cartons of supplies have been shipped from the State office to the local associations. It is the tense moment behind the scenes in the association headquarters in every part of the State. California is out to finish off the Tubercle Bacillus, using every means and technique which has been devised during the thirty-four years of work by the tuberculosis associations.—*News Letter*, California Tuberculosis Association, 45 Second Street, San Francisco.

Seventeen Hospitals Organize
Eighteen Counties Are Served by Hospitals Which Organize

Delegates from seventeen hospitals throughout the Sacramento Valley gave permanency to an organization to be known as the Sacramento Valley Hospital Conference at a meeting at the Southern at noon yesterday.

Mrs. N. T. Enloe of Chico was chosen president. Other permanent officers are R. D. Brisbane of the Sutter Hospital, Sacramento, vice-president, and Daniel Brown, Shasta Dam Hospital, Shasta Dam, secretary-treasurer.

Eighteen Counties Included

The eighteen counties included in the association are Siskiyou, Modoc, Shasta, Lassen, Tehama, Placer, Glenn, Butte, Sierra, Colusa, Sutter, Yolo, Yuba, Nevada, Plumas, El Dorado, Amador and Sacramento.

By-laws were adopted and the president was named delegate to the mid-year conference of the California Hospital Association at Fresno, Saturday and Sunday. Mrs. Enloe will attend.

Program and plans for the future were taken up and the discussion topic of the day was nurses and nursing aids in Northern California hospitals. . . —Chico Record, November 8.

Fabiola Hospital Given Rebirth

An historic name of Oakland's past returned yesterday to the East Bay city's present, after an absence of eight years.

Fabiola Hospital, started with one bed in a cottage in 1877 and discontinued in 1932 when its huge plant was overshadowed with debt from too much philanthropy, was brought back to life through a superior court action.

The action, sought for years by the Fabiola Hospital Association and its president, Mrs. J. P. H. Dunn, authorizes availability of the association's fund for construction of a giant new wing to be built on to Oakland's Merritt Hospital—a new "Fabiola Wing."

There, in a modern \$150,000 annex, containing from forty to fifty beds, the Fabiola Hospital Association will continue to function, and, in line with its traditional policy and that of the Merritt Hospital, will offer "assistance, rather than charity."

Assets made available for construction of the new wing consist of several parcels of real estate and a building at Moss Avenue and Broadway in Oakland. The old Fabiola Hospital was known far and wide, especially to the 14,000 Oaklanders who were born in it. It gave the city its first ambulance, first nursing school, first public health nurse and first scientific diet kitchen.—San Francisco Examiner, November 7.

Annual Rates Per 1,000 Population for Syphilis and for
Gonorrhea, by Cities
Fiscal Year 1940

This statement is issued by the U. S. Public Health Service for the information of health officers in order to furnish current data as to the prevalence of syphilis and gonorrhea. It is based on monthly reports received from city departments of health. (Note: This excerpt gives rates only for California cities listed.)

	Annual rates per 1,000 population	
	Syphilis	Gonorrhea
Los Angeles, Calif. (4).....	4.7	3.1
Oakland, Calif. (2).....	2.7	2.0
San Francisco, Calif.....	3.3	3.6
Total (Average)	4.4	2.0
By States		
California	3.70	2.82
Total (Average)	3.68	1.36

LETTERS

Concerning Annual Registration Tax.

Annual registration fee is \$2 (Chapter 672, Statutes 1935). (Not payable in stamps.) Due January 1 of each year and delinquent 60 days thereafter; also due immediately on receipt of a certificate to practice in this State. Payment must be made whether you practice in California or elsewhere.

Delinquency automatically forfeits your certificate. It may be reinstated on filing a written request (on a printed form 115-124 adopted by the Board) and accompanied by a penalty fee of \$10 in any form other than a personal check.

Full time service as a commissioned medical officer in the U. S. Army, Navy, Public Health or Marine Hospital service does not exempt holders of California licenses from payment of annual registration fee or the imposition of the penalty mentioned in the above paragraph, according to Attorney General's opinion No. NS 1721a, dated July 8, 1939. . . .

Do not fail to register your license in each county where you practice and *notify us of any change of address.*

1020 N Street, Sacramento.

CALIFORNIA BOARD OF MEDICAL EXAMINERS,

CHARLES B. PINKHAM, M. D.,

Secretary-Treasurer.

Concerning Editorial "On Public Relations and Good Will" in November "California and Western Medicine."

(COPY)

THE UNIVERSITY OF SOUTHERN CALIFORNIA
SCHOOL OF MEDICINE
UNIVERSITY PARK
LOS ANGELES

November 19, 1940.

My dear George:

This is to congratulate you on your editorial "On Public Relations and Good Will" in the November number of your JOURNAL. I like it and shall read it to my students.

With best regards,

Yours sincerely,

PAUL S. MCKIBBEN, *Dean.*

Concerning Prospective Legislation in Relation to Cardiac Patients.

(COPY)

CALIFORNIA HEART ASSOCIATION

San Francisco, November 22, 1940.

To the Editor:—At the executive meeting of the California Heart Association held in San Francisco on October 26, 1940, it was voted to submit to the next session of the legislature an amendment to the present laws to provide that the cost of compensating injuries complicated by vocational handicaps, preëxisting impairment or disease, would be spread over the whole industry by insurance on a uniform charge, and that no employer would be financially advantaged by refusing employment to such persons. At the same time such persons, if injured, would receive full compensation benefits as any other employee.

A committee, composed not only of cardiologists and industrial physicians, but compensation specialists as Mr. Warren H. Pillsbury, Mr. H. D. Hicker and Judge Walter Perry Johnson, has been studying this problem for the

past year. The problem undertaken is of vital importance to the employee, employer, and society, as it endeavors to offer a vocational opportunity for the handicapped cardiac by converting him from an unemployable to a happier sphere as an earner, and at the same time safeguard the employer. . . .

45 Second Street.

Yours truly,

CALIFORNIA HEART ASSOCIATION.

By Robert T. Legge, M. D.,

Chairman of Committee on Industrial Problems and Vocational Guidance.

Concerning Pectin and the N. F., VII.

Corona, California,

November 22, 1940.

To the Editor:—The American Pharmaceutical Association in the October, 1940, issue of their *Bulletin of the National Formulary Committee* have presented the monographs for pectin and pectin pastes which are tentatively accepted for inclusion in the National Formulary, Seventh Edition.

Along with the monographs there is presented a rather extensive survey of the world's medical literature on pectin and also considerable information as to the chemical and physical properties of pectin. The early literature on pectin shows it was in 1825 that this interesting carbohydrate was suggested as an antidote for heavy metal poisoning. The extensive medical literature abstracted in the *Bulletin* relates to the uses of pectin (a) in colitis, diarrhea, bacillary dysentery and other intestinal diseases; (b) as a hemostatic when given parenterally; (c) as an antigen; (d) in conjunction with certain heavy metals for oral and external use; (e) and in paste form for wound healing. A final portion of the literature survey deals with investigations explaining the mechanisms involved in the intestinal action of pectin.

The pectin paste therapy for wound healing has had sufficient attention in recent years to make desirable a monograph for the pastes in the N. F., VII. This has become of increasing importance in view of possible connections with National Defense preparations by the medical units of our fighting forces.

It is commendable to see the American Pharmaceutical Association, through their National Formulary Committee, give this timely aid to the medical profession. Their descriptions and specifications of pectin suitable for medical use are the first official recognized guides to users of pectin for therapeutic purposes.

Very truly,

GLENN H. JOSEPH.

Concerning Article and Table on Shell Shock and War Neuroses.

(COPY)

CITY AND COUNTY OF SAN FRANCISCO
DEPARTMENT OF PUBLIC HEALTH

November 19, 1940.

To the Editor:—I am attaching a copy of instructions and information as to war neuroses for use in our Emergency Hospitals and institutions which I thought would be of interest.*

101 Grove Street.

Sincerely,

J. C. GEIGER, M. D.,

Director of Public Health.

*Article referred to appears in this issue in Medical Preparedness department, on page 279.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XIII, No. 12, December, 1915

From Some Editorial Notes:

December—The End of Another Year.—This is the last number of the thirteenth volume of your *Journal*, and in spite of the supposedly unluckiness of the "13" part of it, it has been a very good year. Instead of a decrease in advertising returns, as was expected, we have actually had an increase. While there was no meeting of the State Society, and thus some forty or more papers, which usually come in for publication, did not arrive, there was an ample supply of contributions and of a quality rather above the average. Some notable articles have appeared during the past year. The meeting of the American Medical Association and of the Pan-American Medical Congress brought many distinguished physicians to San Francisco and, of course, to other parts of the state as well. To say that the recent San Francisco meeting of the American Medical Association was a great success is to state what our members know quite well, for so many of them came, saw, heard, and were profited. There never was a time when our members should stand more closely together; when the solidity and stability of the organization was of such great importance and necessity.

Suits for alleged malpractice have greatly increased in number and no physician seems to be safe from such attacks. It is a condition hard to explain, but there seems to be a regular fever of desire to "sue the doctor"; most of the time of the Secretary and half of the income of the Society are taken up with this work alone. To be sure, we win the suits—during 1915 we lost but one, and in that case the verdict was a sympathetic one and for but \$500—but it requires an immense amount of work and time to prepare the cases and try them. A very large number never come to trial, but we have to be ready for them, just the same. This is no time for the airing of personal differences; let them go and become forgotten. And, above all, guard well your tongue against idle criticism of another physician's work or treatment. Without the State Society organization behind them, with its legal department watching their interests, the physicians of this state would have been in a sorry plight during the past year; it would have cost the individual physicians who have been threatened or actually sued, anywhere from \$50,000 to \$60,000 to care for their own interests. And with these few words of summary, may the season's greetings go to each and every one; it has been a good year in many ways—let us see to it that we make the next one better, and carry through it that one thought: Guard well your tongue from criticism.

Business!—Dues are payable on January 1. That is an important matter for you to remember, for the work of the Society is growing in magnitude so fast that business principles must be followed. Do not make any more trouble for the secretary of your county society than you can help—therefore, pay your dues promptly. All memberships terminate on December 31, but in order to give old members a chance to retain their membership, they are allowed sixty days in which to be reported to this office, and the assessment paid. That is, to March 1.* Any old

(Continued in Front Advertising Section, Page 24)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association activities some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

* In 1941, membership lapses if annual dues are not paid on or before April 1, 1941.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M. D.

Secretary-Treasurer

Board Proceedings

Meetings of the Board of Medical Examiners of California

February 24 to 27, 1941—Independent Foresters Hall, 1329 South Hope Street, Los Angeles. No oral examinations.

June 30, July 1 to 3, 1941—Native Sons Hall, 414 Mason Street, San Francisco. No oral examinations.

July 14 to 17, 1941—Independent Foresters Hall, 1329 South Hope Street, Los Angeles. Oral examination, July 14, 1941.

October 20 to 23, 1941—State Capitol, Sacramento. No oral examinations.

All reciprocity applicants must be identified after notification of Credential Committee action and *not* before the application has been filed. If recommended for "direct," appear before one California Board member with photo on which such member will endorse date of your appearance and sign his name, or appear (with photo) before the Secretary of the Medical Examining Board of the State wherein applicant resides and said Secretary will sign, seal and date applicant's photo.

Oral examinations for 1941 (required when reciprocity application is based on a state certificate or license issued ten or more years before filing application in California) will be held commencing at 10 a. m.: January 29, 1941, Board Office, 907 State Building, Los Angeles; April 16, 1941, Board Office, 515 Van Ness Avenue, San Francisco; July 14, 1941, Independent Foresters Hall, 1329 South Hope Street, Los Angeles; October 1, 1941, Board Office, 515 Van Ness Avenue, San Francisco; December 10, 1941, Board Office, 907 State Building, Los Angeles.

No examination given unless completed application and fee has been filed in Sacramento office at least two weeks prior to the date when applicant expects to appear.

No examination will be given unless applicant notifies the Sacramento office of the Board at least two weeks in advance, stating when and where he will appear.

In addition to reciprocity applicants an oral examination may be required of applicants under Section 2194 of the Business and Professions Code relating to the practice of medicine (National Board credentials) or Section 2216 (U. S. commissioned medical officer). Medical Officers Reserve Corps not eligible.

• • •

Written examinations, legal hearings and all other business:

February 24 to 27, 1941—Independent Foresters Hall, 1329 South Hope Street, Los Angeles. No oral examinations.

June 30, July 1 to 3, 1941—Native Sons Hall, 414 Mason Street, San Francisco. No oral examinations.

July 14 to 17, 1941—Independent Foresters Hall, 1329 South Hope Street, Los Angeles. Oral examination, July 14, 1941.

October 20 to 23, 1941—State Capitol, Sacramento. No oral examinations.

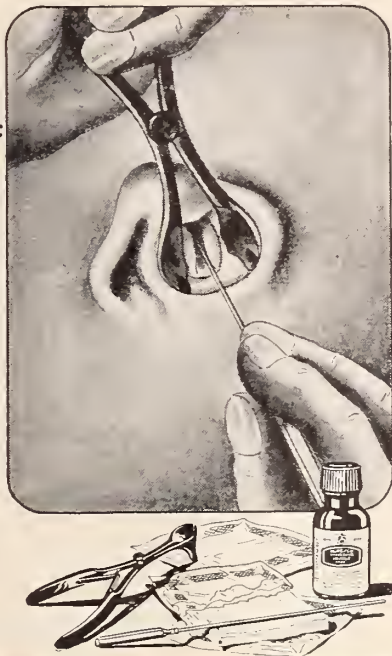
Applications, fully completed, must be filed two weeks before examination together with notification which of above examinations will be taken.

(Continued in Front Advertising Section, Page 30)

†The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.

Methods of Applying NEO-SYNEPHRIN HYDROCHLORIDE

(laeva-alpha-hydroxy-beta-methyl-amino-3 hydroxy-ethylbenzene hydrochloride)



For relief of the Nasal Congestion in:
COLDS • SINUSITIS • RHINITIS

4. NASAL TAMPON

Gentle packing of the nasal cavities with a gauze pack moistened with Neo-Synephrin Hydrochloride Solution $\frac{1}{4}\%$ provides efficient and prolonged decongestion.

In severe cases, the 1% Solution may be desirable. This same procedure is also efficacious in the treatment of epistaxis.

METHODS OF APPLYING NEO-SYNEPHRIN HYDROCHLORIDE INCLUDE:



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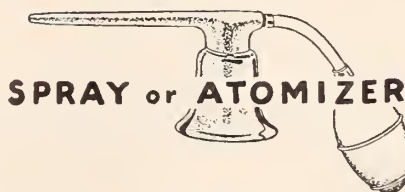
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(AFTER PROETZ)



JELLY



NASAL TAMPON



SPRAY or ATOMIZER

Neo-Synephrin Hydrochloride
SOLUTION $\frac{1}{4}\%$
for dropper, displacement, tampon,
spray or atomizer (non-metallic)

Neo-Synephrin Hydrochloride
EMULSION $\frac{1}{4}\%$
for dropper or tampon

Neo-Synephrin Hydrochloride
SOLUTION 1%
for resistant cases

Neo-Synephrin Hydrochloride
JELLY $\frac{1}{2}\%$
convenient for the ambulant
patient



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Fully equipped for the diagnosis and modern treatment of diseases of the chest, including tuberculosis and other respiratory diseases.

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THE POTTENGER SANATORIUM AND CLINIC

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Monrovia, California

AN INSTITUTION FOR DIAGNOSIS AND THERAPY

CHOICE rooms and bungalows at rates ranging from \$35 per week up, including medical service, general nursing, x-rays, routine laboratory examinations, ordinary medicines and therapeutic pneumothorax.

A few accommodations as low as \$25 per week assigned on special application in selected cases.

In the foothills of the Sierra Madre Mountains, thirty-five miles from the ocean. Surrounded by beautiful gardens.

Close medical supervision. Aside from tuberculosis, special attention is given to asthma, bronchiectasis, lung abscess and kindred diseases.

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SAN FRANCISCO

Physicians' and Surgeons'
Telephone Exchange
Nurses' Bureau

BOARD OF MEDICAL EXAMINERS

(Continued from Front Advertising Section, Page 30)

Young Dai Hahn, M.D., charged with allegedly prescribing for narcotic addicts, was on October 23, 1940, placed on probation for a period of five years under specified terms, among which was that he must within ten days close his office and give up practice for a period of ninety days.

Gottfried Karl F. Schnarrenberger, M.D., charged with alleged use of a fictitious name, was on October 22, placed on probation for a period of three years under certain specified terms.

News

The American Medical Journal of November 2, 1940, page 1566, printed an interesting article on "Fong Wan, a Chinese Herbalist." (Previous entries, June and July, 1926; January, 1928; August, 1931; April, 1932.)

A peremptory writ of mandate, issued on November 8, 1940, commanded the Board of Medical Examiners to immediately vacate and set aside its action of June 27, 1940, revoking the license of Floyd Birdsell Lawton and to dismiss the complaint and dismiss the citation heretofore issued and refrain from performing any act in interference or in derogation of the right of said Floyd Bird-

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

St. Luke's Hospital

SAN FRANCISCO

A Limited General Hospital of 200 Beds



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HOWARD H. JOHNSON, M.D.

Medical Director

KENNETH MONTEAGLE, *President*



Fully approved by the American College of Surgeons and the American Medical Association for Resident and Intern Training.

Limited Facilities for Part-Pay Treatment

sell Lawton to practice medicine and surgery in the State of California.

"A month's investigation climaxed today by a coroner's inquest verdict urging further action, resulted this afternoon in issuing of an abortion complaint for Mrs. May Lorenz of 521 Minnesota Avenue as a result of the death of Miss Dolores Karawaza, 23 . . . following an illegal operation. Joseph W. Williams, special agent for the State Board of Medical Examiners, one of the officers working on a month's investigation preceding the holding of today's inquest, swore to the complaint before Justice of the Peace Grandin H. Miller . . . Special Agent Williams of the State Medical Board testified to investigating the Karawaza girl's death and connecting it with the serious illness of a San Francisco girl who spent considerable time in Dante Sanitarium after undergoing an abortion operation in San Jose . . . Deputy Sheriff Roy Larson testified to searching the Lorenz woman's premises with other deputies previously mentioned . . . and a local physician and finding an operating table covered with oil cloth and several instruments which, he was told, could have been used for abortion operations in the room described by the Karawaza girl." (San Jose *Evening News*, November 8, 1940.)

"On heels of arrest of a local woman on charges of criminal abortion resulting from the recent death of a local Japanese girl, Mrs. Mary Rebello, eighteen, died last night in the County Hospital from peritonitis, which attending physicians informed Coroner Jessie Spalding's office resulted from an illegal operation. . . ." (San Jose *Evening News*, November 11, 1940.)

(Continued on Next Page)



C. I. B. A.

Now Presents

SULFATHIAZOLE

for Pneumococcal and Staphylococcal Infections

SULFATHIAZOLE (the thiazole analogue of sulfapyridine), carefully administered, has shown a definite chemotherapeutic effect in the treatment of pneumococcal and staphylococcal infections.

Its chief advantages, compared to sulfapyridine, seem to be more uniform absorption, less conjugation after absorption, less tendency to cause serious nausea or provoke vomiting, and greater effectiveness against the *Staphylococcus*. Sulfathiazole already has been used in over 2,000 pneumonia patients with good results.

SULFATHIAZOLE, "Ciba" (2-Sulfanilyl-Aminothiazole) is available in 0.5 gram tablets, in bottles of 50, 100, 500 and 1000. Also available are 5 gram bottles of Sulfathiazole crystals for making solutions to be used as a reagent in estimating the sulfathiazole content of the blood.



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SUMMIT

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Las Encinas Sanitarium . . . Pasadena, California

INTERNAL MEDICINE INCLUDING NERVOUS DISEASES

Board of Directors: GEORGE DOCK, M. D., *President*; W. JARVIS BARLOW, M. D.; SAMUEL D. INGHAM, M. D.

Address: STEPHEN SMITH, M. D., F. A. C. P.; CHARLES W. THOMPSON, M. D., F. A. C. P.

MEDICAL DIRECTORS, PASADENA, CALIFORNIA

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You and your assistants are under constant pressure for time. We can help you in a real way with our Bank-by-Mail Service, enabling you to do most of your banking when convenient, day or night, right in your office. Why not open an account today, by mail?

**CROCKER FIRST
NATIONAL BANK**
OF SAN FRANCISCO

California's Oldest National Bank

Member Federal Deposit Insurance Corporation

BOARD OF MEDICAL EXAMINERS

(Continued from Preceding Page)

"Dr. Charles F. Ott, fifty-eight, wealthy Pacific Palisades physician, was under probation today for a two-year period during which he will not be permitted to own any dogs, after having paid a fine of \$500 late yesterday as a part of the penalty imposed for his asserted cruelty to his pets. Municipal Judge Oda Faulconer imposed sentence, suspending a 180-day jail term and granting probation, conditional upon payment of the fine. He was convicted on September 18, on testimony that he beat his pets with a cane and threw one over a fifty-foot cliff back of his home." (Hollywood *Citizen-News*, November 5, 1940.) (Previous entry, November, 1940.)

For More Than a Third of a Century

ACOUSTICON

Has Served the Clients of the Medical Profession

We invite your continued confidence and place at your disposal the facilities of our entire organization

**LET US DEMONSTRATE WHAT ACOUSTICON CAN DO
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457 Powell Street
San Francisco, Calif.

725 Foreman Bldg.
Los Angeles, Calif.

Acousticon is accepted by the Council of Physical Therapy
of the American Medical Association

"A Biblical quotation, 'By the leaves of trees he shall be healed,' was quoted by N. C. Heron, sixty-year old purveyor of a 'cure-all' remedy, when he was fined \$300 by Federal Judge Ben Harrison for violation of the Pure Food and Drug Act. . . . Assistant United States Attorneys Rollin F. Duni and E. H. Law told the court Heron had developed a large market for his medicine through advertisements stating it would 'cure all ills.' Judge Harrison also placed Heron on two years' probation." (Hollywood *Citizen-News*, November 5, 1940.)

"Many a patient, making a wry face, has wished his doctor had to take some of his own medicine. Today Dr. John B. McCann, physician and surgeon, told Superior Judge Thurmond Clarke how he took some of what he thought was his own medicine—and of why he now wants \$25,000 damages. Suing Nathan B. Wager, pharmacist, and a drug company, Doctor McCann charged that last January 29 he wrote out a prescription for himself, to be used in treating an inflammatory digestive condition. The prescription, he said, called for 'aqua cinnamon,' among other ingredients, but when he swallowed a bit of the medicine he finally got from the drug store, it burned his mouth, throat, and stomach so severely he can no longer attend properly to his practice. It turned out, he charged, that 'aqua ammonia,' a caustic drug, had been substituted for 'aqua cinnamon.' 'It was ten times as hot as hot soup,' he told Judge Clarke." (Los Angeles *Herald and Express*, October 10, 1940.)

"After a three-day trial in Municipal Court a jury returned a verdict yesterday finding Amos Clapp, licensed chiropractor, guilty of practicing medicine without a

(Continued on Page 38)

Advertisers in your OFFICIAL JOURNAL will appreciate requests for literature

FACILITIES TO FILL YOUR PRINTING NEEDS

... With Most Satisfying Results Secured
Without Costly Waste of Time and Effort

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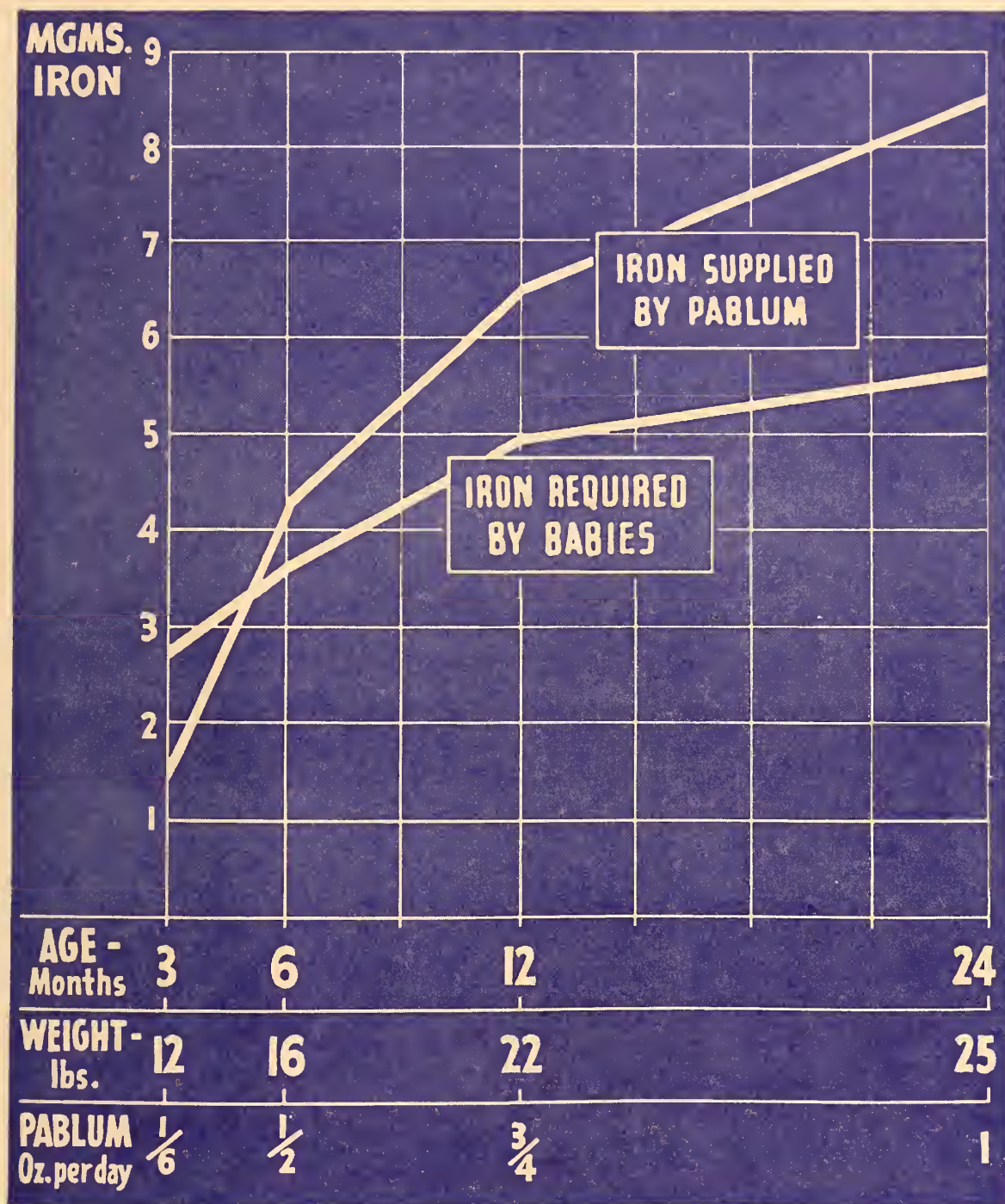
BOARD OF MEDICAL EXAMINERS

(Continued from Page 36)

license. The jury deliberated less than an hour. The case was heard by Judge Percy Hight, with City Prosecutor Lyman B. Sutter and Manley T. (Walter N.) Anderson of the State Medical Board prosecuting, and Attorney William O. Wanzer for the defense. The charges involved the alleged treatment of social diseases by hypodermic injection. The defense served notice that a motion for a new trial would be made on Monday, when Clapp is scheduled to come up for sentence." (Long Beach Press-Telegram, November 2, 1940.)

"Harry Y. Cohen, fortune teller and spiritualist who was convicted in the justice court here of bilking two of his clients of \$136 on the promise that he would locate buried treasure for them, has been released from the county jail. Justice of the Peace Harry S. Hills suspended the remainder of his six months' sentence after he made restitution to his victims and paid the costs of his returning from Bakersfield, where he was arrested. Cohen told newsmen he intended to abandon the fortune-telling business and return to his home in Denver, Colorado, to enter the private detective business." (Sacramento Bee, October 24, 1940.)

"Dr. Alex J. Otten, McCloud physician, was held in the county jail here in lieu of a \$500 bail on a charge of driving while intoxicated. Doctor Otten was arrested yesterday afternoon on U. S. Highway 99, south of Weed, by Highway Patrolman Edward Axtell." (Press dispatch dated Yreka, October 29, 1940, and published in the Sacramento Bee, October 29, 1940.)



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ments are based on the conservative estimate of the Council on Foods, i.e., 0.5 milligram per kilogram of body weight. The iron supplied by Pablum is calculated on the basis of 8.5 mg. per ounce. On account of its thorough cooking Pablum is well tolerated, having been fed without gastrointestinal upset as early as the first month. Bibliography on request. Mead Johnson & Co., Evansville, Ind., U.S.A.

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